

**‘The Emerging Butterfly’ how can a boy  
considered likely to receive an ADHD diagnosis  
at age 5 be provided with a different  
developmental experience? An extensive clinical  
exploration with an under 5 boy with an  
anticipated diagnosis of ADHD, and his journey  
towards health with the aid of intensive  
psychotherapy**

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**Pseudonyms have been used throughout  
to protect patient confidentiality**

***Wild boy, horrid child  
Come into my room  
Evil lad, you know you're bad  
Find a way to bloom***

***Restricted by your family  
Failing to just thrive  
Unloved and hated daily  
Come learn how to survive***

***A new experience beckons  
It might be tough at first  
Allowing different boundaries  
Development of trust***

***Each session brings you closer  
To the other parts of you  
Parts that have been stunted  
Will now come into view***

***\*\*\*\*\****

***Loved boy, thoughtful child  
Come into my room  
Happy lad, you know you're glad...  
Time to leave me soon***

## **Abstract**

This thesis explores the issue of ADHD and its diagnosis in the very young. Also one of my tasks has been to illustrate how offering a four year old boy intensive psychotherapy can be very beneficial for his emotional development and general well being. The detailed analysis of clinical material and commentary covering four phases are explored and further discussion is presented that question whether there is a distinct link between a lack of early containment and ADHD symptomology. The first three phases chart the boy's gradual progress whilst receiving intensive psychotherapy over the period of one year. The fourth phase documents what happened after the first year of treatment.

ADHD origins and symptomology are described as are the more controversial aspects of diagnosis and treatment. The possibility of knee-jerk diagnosis is thought about as is the ADHD symptomology of the parent.

A grounded theory qualitative research methodology is applied. The grounded theory approach allowed for the emergence of a theme around the boy's different uses of the room in his unconscious search for a container to help his manage his internal anxiety. Recommendations for Service, Clinical and Research are offered.

It is the authors hope that this research will contribute to the knowledge base of child psychotherapy and aid other professionals who work with challenging young children who have ADHD symptomology.

## **Declaration**

This thesis represents my own work research and original work. It cannot be attributed to any other persons or person.

**Name:** Davina Brown

**Award:** Professional Doctorate in Child Psychoanalytic Psychotherapy

**Date of Submission of Thesis:** November 2011

**Signed:**.....

**Date:**.....

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## Introduction

This investigation is concerned with the interface between the now common psychiatric diagnosis of ADHD in young children, and the perspectives of psychoanalytic child psychotherapy on such children. It will outline current definitions of ADHD and the normally preferred 'methods' of treatment. Psychoanalytic (Orford, 1998, Widener, 1998: Cleve 2004) and psychiatric literature (*WHO, 1993 International Classification of Diseases, 10<sup>th</sup> revision, (ICD-10) Classification of Mental and Behavioural Disorders Diagnostic Criteria for Research*) surrounding some of the controversies about ADHD will be examined and compared (Turner & Sahakian, 2006, Lakhan & Hagger-Johnson, 2007). A brief history of psychopathy will be examined, focussing on its possible links to ADHD (Ramsland, 2010, Lynam, 2005). The possibility of children receiving a premature diagnosis will be also be explored, with regard to the contributions of both early internal developmental processes and external circumstances.

The clinical work with this boy was completed before this research as a doctoral study started. The project undertaken is a re-analysis of in-depth data which had already been compiled during the course of treatment. The author believes that a re-analysis of this data will help clarify the meaning and significance of an early child psychotherapy intervention. The re-analysis was undertaken in a systematic way, with reference to relevant supportive literatures.

This case-study will seek to describe both the presenting condition of the child early in treatment, and the development that took place during the treatment process. It will explore from this evidence whether early psychotherapeutic intervention can favourably influence a path of development that had been predicted to lead to an ADHD diagnosis.

The research will be questioning whether early intervention (in the form of intensive child psychotherapy) with the second son of a father with a diagnosis of antisocial personality disorder, frontal lobe syndrome, was useful as a therapeutic tool to help prevent him receiving a similar diagnosis to that of his

father. The material aims to show via the use of and reference to a single case study, that by offering 'potentially diagnosable' ADHD children under five years of age intensive psychotherapy, there is a way that children can avoid being assigned a diagnostic label, and possible harmful medication, and can enjoy a more normal developmental pathway. A psychoanalytic formulation of the original internal state of the boy at the beginning of therapy will be discussed and compared to his internal state one year into intensive therapy. External circumstances and changes will also be evaluated to determine what may have helped or hindered his progress.

There will be a concise examination of the current psychiatric diagnosis of ADHD (*WHO 1993 International Classification of Diseases, 10<sup>th</sup> revision, (ICD-10)*). Questions will be raised as to the choice of therapy for these children. The controversies surrounding the efficacy of medication will be mentioned as well as the uncertainty of the long term side effects of taking medication for patients. The present method of evaluation of ADHD symptoms will be thought about, together with the capacity of families to claim Disability Living Allowance (and Carers Allowance) if their child meets the current Government criteria – and the implications this might have on both the child's future development, and the long term cost repercussions that this produces for the health service.

The research methodology that will be used is extensive clinical data of a single case study (a qualitative research method). Process notes of sessions with Kieron will be presented and interpreted using psychoanalytic theory and thinking. The sessions are presented in process note form together with an analysis of the ADHD type behaviours and interactions observed in the therapy room, specifically over the period of twelve months. A commentary that incorporates supervisory notes and further thinking around the case material will also be presented for reflective purposes. I will make use of the methods of Grounded Theory – first developed by Glaser & Strauss 1967 and subsequently adapted for use in a psychoanalytic context - to analyse these sessions. I will be using carefully documented psychotherapy sessions and illustrate these with quotations to help capture the boy's personal perspective and experiences.

The proposed plan of work will examine developments – both internally and externally - recorded over the period of one year of intensive psychotherapy. These methods will allow me to offer my detailed observations and descriptions, which will be scrutinised in depth. I consider personal experience and engagement as an important part of my enquiry and critical to understanding the therapeutic process undertaken.

Grounded Theory is still the most widely used and accepted method of psychoanalytic research among clinicians (Rustin, 2000). The single case study in psychoanalytic terms presents an informed outline of the workings of an individual; what makes them special and interesting. This can be used singularly, but may also reflect a similar situation in another individual. However, this is not the objective of the study; it is primarily an exploration into the individual to clarify his particular qualities with hopefully the possibility of enhancing and expanding current thinking in a particular area. As a form of research it is defined by its interest in individual cases, not by the methods of inquiry used (Stake, 1994) (*as cited in* Denzin & Lincoln, chapter 14). It draws attention to the question of what *specifically* has been learned from the single case in question and its focus is the understanding of the individual case, rather than a generalised overview. By analysing a single case study one can achieve a deeper understanding, which can allow for the development of hypotheses that may be used to test out in further case studies or larger scale research.

I will examine the literature on single case study methods, to clarify what are the strengths and limitations of this method for advancing psychoanalytic knowledge and understanding. (Caper, 1994, Damasio, 2000, Fonagy & Moran, 1993).

I will discuss the psychoanalytic theories of containment (Bion, 1964), attachment (Bowlby, 1969) as well as the early mother - child relationship (Winnicott, 1962 & 1960). The concepts of gratitude and early anxiety situations (Klein, 1957, 1932) will be examined. Formulations will be offered of the psychic space that the boy needed to develop in order to survive in such a chaotic environment (Cleve, 2004). The difficulties of working with children from

very deprived backgrounds (Boston & Szur (Eds), 1983) and the concept of the “fighting spirit” in a psychodynamic way will also be considered.

I will be drawing on my previous experience of working in a PRU (Pupil Referral Unit for behavioural and emotional problems) in my capacity of Unit Counsellor. Here I saw several children aged between 11-14 years, who had a diagnosis of ADHD. Since then, my work as a School Counsellor and more recently Trainee Child Psychotherapist and now as a qualified Child & Adolescent Psychotherapist, has led me to develop my interest in this area, and I want to contribute to the debate that I feel needs to be explored further. I would like the range of treatments currently available to help these children to be revised and updated, and offer my clinical experience of a younger child as a possible predictor of the efficacy of early intervention.

Although psychotherapy is not the ‘usual’ choice of intervention for this type of child (NICE Guidelines, 2008) its implementation may well demonstrate significant incentives for authorities whose aim is reduction of expenditure, as well as health and well-being of the child. I will consider the Cambridge study which was carried out in 1994 and revised in 2001, (Farrington, 2001) which is the single most important study today that is used for predictive behaviour/conduct problems for the future and extending the thinking around what can be offered to these children in our clinics by way of alternative help (Widener, 1998, Pozzi, 2000).

The Clinic Psychiatrist was already seeing Kieron’s half brother – diagnosed with ADHD and on medication – Ritalin. He saw Kieron and prescribed Melatonin 2mg nocte to aid his disruptive sleep pattern. In his report the Clinic Psychiatrist stated that he had been referred for extreme hyperactivity, but that during his assessment he was not hyperactive – mum had stated that this was extremely uncommon.

To provide evidence of an independent perspective I have included in this thesis supervisory comments in the commentary column of the process session notes in the phases. There will also be a consideration of how these comments influenced the treatment process.

University Ethics Committee Permission has been sought and granted even though I did not undertake any new clinical work for the purpose of this investigation. Detailed process notes of completed clinical work and supervision will be used but only retrospectively and anonymously. The case study being used in this project was undertaken as part of my clinical training and did not involve any deviation from usual clinical practice.

### **Case Material**

In the following pages I will be documenting and discussing in detail the case material from six sessions. These sessions have been specifically chosen to demonstrate what I believe to be the important issues arising in this case. I have divided the material into four phases. The first phase will include background material and the session notes following my initial meeting with the Principal Social Worker, Viviane and Kieron, followed by a discussion of the meeting and the issues arising. This session will also include a brief discussion of the assessments prior to treatment. The second and third phases will offer detailed case material that originates from individual psychotherapy sessions (two sessions in each phase). These phases have been selected in order to demonstrate the three stages of Kieron's development as I understood it, during his first year in intensive psychotherapy treatment. No such selection of sessions, or temporal phasing of the material, can be completely definitive, but I have found that the method of selection I have chosen has enabled me to find meaning in the material and to derive clear hypotheses from it.

The phases, together with a summary characterisation of their main qualities are as follows:

- Phase 1 - Initial Meeting – Uncontrollable, wild, omnipotent, psychopathic stage
- Phase 2 - Intermediate Sessions – the beginning of therapy, the beginning of containment and engagement in therapy, coupled with more ambiguous response towards boundary setting which demonstrated Kieron's internal struggle against a robust object in the sessions

Phase 3 - The end of the first year – Emergence of normal developmental play, and something far more human and beautiful

Phase 4 - The second year – three times weekly psychotherapy. Demonstrating the continuing benefit that Kieron obtained from further, slightly less intensive work

The first phase includes the background of the case and a detailed session and process notes and thoughts around this initial meeting. The second and third phases will contain two sets of full process notes from two different sessions together with detailed notes of reflective thoughts and themes that emerged from them. The final - fourth - phase includes detailed process notes from one session, and extracts from later sessions that demonstrate Kieron's response towards the end of his therapy. Why these particular sessions were chosen and what distinguishes them from other sessions that Kieron attended is discussed in more detail in the Methodology chapter. (See below, page 32).

## **Literature Review**

When I first searched for literature linking child psychotherapy to ADHD the number of articles published appeared to be very limited. However, on further exploration I was surprised to discover considerably more material than my initial search had produced once this was widened to include psychoanalysis. This I thought to be a positive sign that I was “not alone” in my thoughts about the efficacy of child psychotherapy as a useful alternative intervention to long term medication. I also broadened the search due to the particular nature of the case in question, i.e. Kieron was not only a deprived child with a prognosis of ADHD but a boy who had a violent father, and a boy who had himself committed many criminal and unsociable acts himself prior to age 4.

I have broken down the literature review into four sections, firstly a description of what ADHD is and how it is treated by psychiatrists currently, secondly the controversies surrounding ADHD, thirdly, psychopathy and its possible links to ADHD, and finally research into the child psychotherapy and psychoanalytic approach towards ADHD, the different explanatory thinking which this approach brings to it, and the different implications for treatment of this condition.

### **An introduction to ADHD – what is it?**

Current literature (Ross & Ross 1982: Barkley 1998) demonstrates clearly that modern conceptions of ADHD and its classification differ considerably from descriptions and definitions that were held in esteem up until a decade or so ago. These authors state that the first description which focussed the attention of the medical community on the behavioural condition in children has been attributed to a London paediatrician, George F Still in 1902, whose articles were published in *The Lancet* in the same year. This has been brought into questions more recently by Palmer & Finger, (Palmer & Finger, 2001) who claim that a Scottish born physician, Alexander Crichton published a book in 1798 in which he carefully described one type of attentional problem in young people in a way that meets the current criteria listed for Inattention under ADHD in DSM-IV. Currently, ADHD is described as the most common neurobehavioral condition of childhood (Furman 2006).

There are two diagnostic manuals which psychiatrists currently employ: the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) which categorises types of 'Attention-Deficit/ Hyperactivity Disorder' (ADHD) and the International Classification of Diseases 10 (ICD-10).

DSM-IV sets out the diagnostic criteria that define ADHD and its subtypes: predominantly inattentive, predominantly hyperactive-impulsive, combined, or not specified (American Psychiatric Association, 1994)

The ICD-10 category of Hyperkinetic Disorder describes a narrower and more severe type of ADHD. Nearly all cases of Hyperkinetic Disorder are included in combined type ADHD. However, only the most severe of those with combined type ADHD whose symptoms are significantly impairing across a range of settings will meet the criteria for Hyperkinetic Disorder. The distinction is important as the presence of Hyperkinetic Disorder may predict a differing response to treatment.

Both DSM-IV and ICD-10 concur in the following areas:

- that symptoms must persist for at least 6mths
- be inconsistent with the developmental level of the child
- start before age 7
- cause significant impairment to functioning
- be present to some degree in more than one setting (e.g. home and school)

The symptom that I think is particularly significant in making a diagnosis is *"cause significant impairment of functioning"*. Many children and young people display some of the behaviours associated with ADHD but often these don't lead to impaired functioning, and might be considered to be normal behaviour. Bailly, (2005), states that as ADHD is an:

*"Operationally defined concept which is built on a series of behaviours, none of which is specific (contrary to phobias, obsessions, post-traumatic stress disorder, panic attacks, depression, autism, Tourette syndrome,*



*etc). There is therefore much room for interpretation of these behaviours, and clinicians with opposing views would probably agree only on the most serious of cases” (Bailly, 2005).*

ADHD as defined by DSM-IV is estimated to affect 3-5% of school age children. This means that the average UK classroom will include at least one child with ADHD. Several studies suggest that the more severe subset of Hyperkinetic Disorder (ICD-10) affects about 1.5% of primary school children. ADHD is more common in boys than in girls with a ratio of approximately 3 boys to 1 girl. However, it appears that many girls with ADHD symptoms are currently undiagnosed and therefore unrecognised (Mash & Wolfe, 2007), which means that in a typical CAMHS clinic the ratio is closer to 9 boys to 1 girl. Once a diagnosis has been given, it often lasts through to adult life – making the correct diagnosis essential.

Children with ADHD are often found to have one or more other mental health disorders or learning disabilities coexisting, (SIGN, 2001, British Psychological Society, 2000, Arcelus & Vostanis, 2003). These may include: conduct disorder (persistent lying, stealing, truancy, vandalism etc) and oppositional defiant disorder (ODD – a pattern of abnormally uncooperative and defiant behaviour), anxiety and depression, neurodevelopmental delays – e.g. language, sensory motor coordination, handwriting, reading ability, autism, tic disorders.

Research establishing whether there is an association between ADHD in childhood and drug abuse, alcoholism and smoking in adolescence and early adulthood is conflicting (Esser et al, 2007), and more recently there have been publications disproving this connection (Kessler et al, 2006). Children with a diagnosis of ADHD have also been shown to evoke “negative parenting”, which becomes cyclical, so that parents and children “maintain each other’s negative patterns of interaction” (SIGN, 2001). The condition is recognised as a persistent condition, and although some of the ADHD symptoms do lighten over time (Bramble, 2003), it has been demonstrated that undiagnosed or untreated ADHD can lead to major social and behavioural difficulties in adulthood (Chu, 2003, Swanson et al, 1998, Taylor et al, 1996).

Farrington conducted the Cambridge Study into Delinquent Development in 1994 and updated his findings in 2001 (Farrington, 2001). He outlined six key independent childhood predictors of offending:

Anti-social child behaviour

Impulsivity

Low intelligence or attainment

Family criminality

Poverty

Poor parental child-rearing behaviour

The main policy implication put forward in the revisions by Farrington in 2001 stated:

*“In order to reduce offending and anti-social behaviour, early prevention experiments are needed for targeting four important predictors that may be both causal and modifiable: low achievement, poor parental child rearing behaviours, impulsivity and poverty” (Farrington, 2001)*

Current research would suggest that young people and adults with ADHD have higher rates of unemployment, criminality, substance misuse and antisocial behaviour than young people and adults without ADHD (SIGN, 2001; Thapar & Thapar, 2003; Barkley, 1998). With this research in mind, the importance of early and accurate diagnosis is widely accepted, but may inadvertently have led to the heightened tendency towards over diagnoses of ADHD in the UK.

The exact aetiological pathways underpinning ADHD are not known, but current thought indicates the importance of biological factors.

The core features of ADHD in DSM-IV are:

- Marked restlessness
- Inattentiveness
- Impulsivity

- That the above three be present across different situations (e.g. home, school, elsewhere)
- Evidence for these to be present for at least six months
- Evidence for these to be present before 7 years of age

Studies of the structural and functional brain imaging of people diagnosed with ADHD determined abnormalities in the frontal, temporal and parietal cortex, basal ganglia, corpus callosum and cerebellum. These brain regions are involved in a range of cognitive processes including the regulation of goal directed and motivated behaviour, memory and planning (Seidman et al, 2005). There has also been speculation about a genetic risk, with twin studies suggesting a strong genetic component, with heritability ranging from 65-90% (Harrington et al 2001).

Molecular genetic studies conducted have found associations with variations in several genes related to dopaminergic neurotransmission which link to sociability (Bobb et al, 2004). These findings are consistent with the known clinical efficacy of stimulant and noradrenergic medications. However there is evidence for considerable genetic (and clinical) heterogeneity and it is important to note while these genes are associated with an increased risk of ADHD, many of those with these genes don't have ADHD. Ryan (Ryan, 1999) draws attention to the fact that although links between disease and a particular genetic locus identifies a chromosomal region that influences susceptibility; it does not prove that a particular gene has a direct, biologic effect on liability. He stresses that:

*“Evidence for causation is generally provided by other lines of evidence, including biochemical studies, analysis of pharmacologic responsiveness profiles, and examination of the effects of targeted gene disruption in animals”.* (Ryan, 1999)

More recently in October 2010, Dr Anita Jayson (Cardiff University), conducted research that she described as “the first study directly looking at the genes”. She also noted that genes do not tell the whole story. The genetic variations

raise the risk of ADHD, but do not guarantee the disorder will develop; she highlights the importance of environmental factors:

*"If the mother is very anxious during her pregnancy, high levels of stress hormones in the womb can double the chances of ADHD if the child already has a genetic risk. In childhood, if there's disruption of some kind in the family home or lack of structured activities, support or supervision that may contribute to problems in a child with a genetic tendency to ADHD." (Jayson, 2010)*

Other environmental factors that have been identified in children diagnosed with ADHD, include; obstetric complications; low birth weight; prenatal exposure to nicotine and alcohol; brain diseases and injuries.

The medicines licensed in the UK for ADHD include both stimulants and non-stimulants. Stimulants - known as methylphenidates – are usually the first choice by psychiatrists. If symptoms fail to respond to methylphenidate then dexamfetamine is used. There is a rapid reduction reported in symptoms (notably restlessness, inattentiveness and impulsivity) in the majority of patients, whilst in the longer term improved quality of social interactions; decreased aggression and increased compliance have been noted. Adults who responded to Methylphenidate in a short-term, placebo controlled trial, responded to long term treatment (over 1 year) with marked improvements in ADHD symptoms and psychosocial functioning (Wender et al, 2010). Bailly (Bailly, 2005) reports that stimulant medication is not a specific treatment of ADHD and appears to act similarly on children and adults with and without hyperactive behaviour by decreasing motor activity, increasing vigilance and improving performance at a learning task.

The effect of methylphenidate lasts only for a few hours, and so three daily doses are recommended. The most commonly used brand of methylphenidate in the UK is currently Ritalin. In recent years, longer acting formulations of methylphenidate e.g. Concerta XL (12hr action) have been designed to mimic a three times daily regime, making school time and early evening medication unnecessary. Equasym XL is an 8 hr formulation designed to replace twice

daily dosing. Eliminating school-time and early evening dosing can avoid stigma and increase privacy for the child. There is also a thought that this may improve compliance from the child whilst at school as it negates the necessity for school intervention, but there is currently no evidence to substantiate this claim. From the point of view of the school, not having to dispense a controlled medication would be viewed as a great advantage, in so far as they do not have to become involved in the administration of medication. Bailly (Bailly, 2005) warns however that the clinical response to stimulant medication cannot be used as a form of diagnostic test. Adding that the risk of addiction and misuse is not negligible and illicit use of methylphenidate has been reported in UK schools.

Since May 2004, the non stimulant atomoxetine has been licensed in the UK for the treatment of children and adolescents with ADHD. Atomoxetine has also been shown to be effective at reducing symptoms and improving functioning in randomised placebo-controlled studies (Kratohvil, et al 2002).

Currently in the UK, the National Institute for Health and Clinical Excellence (NICE Guidelines September 2008) publication entitled *“Attention Deficit Hyperactivity Disorder – Diagnosis and management of ADHD in children, young people and adults”* sets out recommendations of how to diagnose and manage ADHD in children aged 3-11 years, older young people 12 + years and adults. In the introduction it states:

*“Symptoms of ADHD are distributed throughout the population and vary in severity; only those people with at least a moderate degree of psychological, social and/or educational or occupational impairment in multiple settings should be diagnosed with ADHD. Determining the severity of ADHD is a matter for clinical judgement, taking into account severity of impairment, pervasiveness, individual factors and familial and social context.*

*Symptoms of ADHD can overlap with those of other disorders, and ADHD cannot be considered a categorical diagnosis. Therefore care in differential diagnosis is needed. ADHD is also persistent and many*

*young people with ADHD will go on to have significant difficulties in adult life”*

The guidelines call for health trusts to develop ADHD teams within their service which offer age-appropriate training programmes for the diagnosis and management of ADHD. These guidelines arose in response to surveys that found that clinicians arrived at different diagnoses, despite using the same assessment criteria and procedures McKenzie & Wurr (2004). It has also been pointed out that the reports of parents and teachers can be very subjective; it has been recommended that their content should therefore be confirmed by the specialist seeking to diagnose ADHD by interviewing the parent or teachers concerned (Swanson et al, 1998).

### **The Controversies Surrounding ADHD**

The prescribing of Methylphenidates for the use and treatment of ADHD has aroused considerable criticism, not least the prescribing of psychostimulants to children in order to reduce the symptoms of ADHD (Lakhan & Hagger-Johnson, 2007). Lakhan & Hagger-Johnson’s research states that commentators have argued that prescribing is influenced by five myths:

- 1) children are little adults;
- 2) children have no reason to develop depression or anxiety;
- 3) psychiatric disorders are the same across adults and children;
- 4) children can be prescribed lower doses of the same drug;
- 5) drugs are preferable to alternative treatments and are more successful.

Their article goes on to cite several lines of evidence which suggest that these are incorrect assumptions. They also express concern about the validity of the diagnosis of ADHD itself stating that it is still a controversial diagnosis. Further they state that it is disturbing that “elevated but still developmentally normal levels of motor activity, impulsiveness or inattention” traits of childhood could be

inappropriately interpreted as ADHD and they cite Vitiello's research (Vitiello, 2001) to substantiate this. Jaak Panksepp (Panksepp, 2002), notes that psychostimulants that are routinely prescribed to hyperactive children are especially effective in reducing playfulness. He suggests that many of the so called ADHD symptoms actually reflect playfulness and the medicines may be considered to be effective in part because they reduce such behaviours in classroom settings. He quotes from a previous article adding that:

*"This idea also forces us to consider what types of beneficial effects for brain development might be advanced by allowing abundant **natural** play during childhood, and whether administration of play-reducing psychostimulants might reduce such benefits"* (Panksepp, 1988)

Panksepp (Panksepp, 1988) discusses how there appears to have developed an intolerance towards natural childhood playfulness, and describes this as a tragedy in the making. One might well question the increasing numbers of reported children with ADHD symptoms and ask who is unable to contain, who is unable to tolerate? It would be interesting to evaluate whether these claims are more frequently experienced by single parent families for example where there is a lack of shared parental responsibility, or by newly qualified teaching staff who face the challenges of a classroom full of children in which there is likely to be at least one child who has ADHD symptomology.

Dr S Timimi (Timimi, 2005) a child and adolescent psychiatrist argues in his article entitled '*ADHD: the medicalisation of naughty boys*' that ADHD is a Western cultural construct and that no evidence exists for its being a diagnosable condition. He states that:

*"According to the findings of epidemiological studies, four times more boys than girls have the symptoms of ADHD. Yet no one seems to question why this would be so, if we are talking about a biological abnormality."*

Dr Timimi states that the assertion that ADHD is a genetic condition is a cultural construct, one that studiously ignores significant matters of individual context – and speaks of seeing children who: were missing their absent father; had

parental relationships in trouble; were children from failing schools; had depressed mums failing to cope; from families who had no family to help them; were fostered children who expected rejection; were children who couldn't grieve for the death of the person they loved most; were clever children who had learned how to manipulate the system; were pupils of frightened teachers who didn't know how to handle the boys in class; had parents too busy or exhausted or lost to make real contact with them; were now taking dangerous drugs, while the problems in the psychosocial context remained unaddressed. Dr Timimi appears to be highlighting the pitfalls of medication without the child's emotional and psychological needs being met; I think that child psychotherapy would be a pertinent starting point to address the child's emotional and psychological needs.

Psychological side-effects of long term treatment have been investigated by McGuinness (McGuinness, 1989) who conducted a follow up study of children with ADHD prescribed Ritalin. He found that:

*"The children come to view the drug as a crutch and feel helpless in controlling their own behaviour without it"* (McGuinness, 1989)

There have also been comments that argue that Methylphenidate should be restricted in its use (Kidd, 2000). Some campaigners allude to the fact that Ritalin is prescribed for cosmetic reasons i.e. cosmetic psychopharmacology. This term refers to the *"pharmacologically improving the brain functioning of healthy, normal individuals"* (Turner & Sahakian, 2006), and add that the taking of methylphenidates to enhance exam results should not be overlooked. The number of prescriptions written for Ritalin far outweighs the estimated prevalence of ADHD suggesting that cosmetic psychopharmacology is prevalent (Vitiello, 2007). The use of methylphenidate as a treatment of ADHD in the USA has led to legal action- malpractice where the prosecution cited a lack of informed consent, and inadequate information about the side effects of methylphenidate medication.

Despite the prescription of methylphenidates to large numbers of children diagnosed with ADHD being noted as controversial (Anderson 2001), with



McGuinness (McGuinness, 1989) stating that ADD and hyperactivity as a syndrome simply does not exist some twenty one years ago, it not only persists, it thrives. There is seemingly a lack of thought given to a possible establishment of the relevance and importance of a different approach or even the possibility of one being considered. Bailly, (Bailly, 2005) suggests that it is possible that prescription practices in the treatment of ADHD are influenced by the sheer pressure of advertising.

There are a wide range of new medical categories in psychiatry and medicine that did not exist four decades ago: ADHD is only one of these. There can be social as well as medical dimensions to these changes of categorisation. A medical diagnosis transforms a hitherto “unorganised illness” into an “organised illness” (Balint, 1957) i.e. it is made legitimate. Indeed, scepticism about the disorder in general has been raised in a series of critical books concerned about the “epidemic” diagnosis and drug treatment of ADHD; “Running on Ritalin” (Diller, 1997), Talking back to Ritalin (Breggin, 1998) Ritalin Nation (De Grandpre 1999).

The principle of equifinality, the idea that *“the same end state can be reached from different initial conditions or through different processes”* was introduced by Cicchetti & Rogosch, (Cicchetti & Rogosch, 1996). The DSM which diagnoses ADHD symptomology fails to differentiate manifest symptoms (phenotypes) from underlying processes (genotypes) that give rise to the symptoms. Therefore, children are being diagnosed as having the same condition whilst not being likely to be homogeneous in terms of their underlying pathogenic processes and are unlikely to respond equally to the same treatment. (Shirk et al, 2000) – This might be likened to a “one size fits all” approach.

Peter Conrad and Debbie Potter (2000) in their paper *“From Hyperactive Children to ADHD Adults: Observations on the Expansion of Medical Categories”*, suggest how the interaction of lay and professional claims-makers, rather than “medical imperialism” typically underlies the medicalisation process. The paper puts forward the idea that the increase in diagnosis of children and the multi-media way that these are conveyed to the public in general i.e. internet

access, word of mouth, tabloid press, and to a much wider audience than previously, has had a dramatic effect on the case of adult ADHD popularisation. They indicate the expansion of other now “popular” medicalised categories which were developed and legitimated for one set of problems, only to be later extended or re-framed to include a broader range of problems. For example:

- 1) PTSD – originally the term was used for veterans of the Vietnam War, more recently applied to rape and incest survivors, disaster victims, or witnesses to violence.
- 2) Child Abuse – originally referred to physical battering of children, more recently extended to apply to sexual abuse, neglect, child pornography and exploitation
- 3) Multiple Personality Disorder – in 1972 this was a very rare diagnosis (less than 12 in 50 years). By 1992 thousands of multiples were diagnosed – due to the re-conceptualisation to “dissociative identity disorder” in DSM-III-R with less restrictive criteria and an association with child abuse (Hacking 1995).

In Hacking’s book entitled “The Social Construction of What?” (Hacking 1999), the complex idea of “social construction” is explored. Hacking’s states that when an illness, condition or phenomenon becomes visible - by becoming a diagnosable illness, or socially recognisable - it becomes what is known as a “social construct”. He stresses that a social construct is not synonymous with actuality, but it does influence the people to whom it is applied i.e. it can change their reality and the perception of others towards them. Hacking suggests that the classification scheme used by psychiatrists is contingent and self-reinforcing, as opposed to simply objective and inevitable. I believe this argument is applicable to the classification of ADHD, and certainly is relevant to the case of Kieron. He came to his sessions telling me he had ADHD – which had not and has not been diagnosed, and not mentioned by me to him. When asked what he understood by him having ADHD he replied that it meant that he was naughty. His saying this demonstrates how these classifications can become part of the way quite young children come to see themselves. This may prove to be quite confusing for them.

## **Psychopathy and its Possible Links to ADHD in Childhood**

In the GP referral for Kieron it detailed him drowning a pet kitten, and throwing a hamster against the wall until it was dead. Although cruelty to animals in childhood was not always considered as being symptomatic of any particular psychiatric disorder, it was introduced by MacDonald (MacDonald, 1965) as one of, what he considered to be, three indicators of psychopathy and future episodic aggressive behaviour known as the Macdonald Triad:

Bedwetting

Cruelty to animals

Fire-starting

In 1987 cruelty to animals was included by the American Psychiatric Association in DSM-III and has since been retained in its updated version DSM-IV. It is to be found as one of the diagnostic criteria for conduct disorders (Criterion 5, cruelty to animals).

Weatherby (Weatherby et al, 2009), research proposed that bedwetting was not a significant factor, their research found that future psychopathy very much depended upon whether early an intervention with young children had been successful or not.

According to McClellan (Mc Clellan, 2007), the following childhood indicators of psychopathy should be viewed not merely as the type of behavior, but more in terms of its relentless and unvarying occurrence. She indicated that not all of the indicators need be present concurrently, but at least a number of them need to be present over a period of years. These indicators are sufficient - but not necessary - indicators of possible psychopathy.

- An extended period of bedwetting past the preschool years, which cannot be attributed to any medical problem
- Precocious sadism often expressed as profound animal abuse
- Pathological fire setting lacking in obvious homicidal intent. This is the deliberate setting of destructive fires with utter disregard for the property

and lives of others. Not to be confused with playing with matches - which is not uncommon for pre-school children.

- Lying, often without discernible objectives, extending beyond a child's normal impulse not to be punished. These lies are so extensive it is often impossible to know lies from truth
- Theft and truancy
- Aggression towards peers and relatives. The aggression can include physical and verbal abuse, getting others into trouble, or a campaign of psychological torment

From the above list of indicators Kieron would not typically meet the criteria for psychopathy; however, some of his more disturbing symptoms would still raise concern and might alert professionals to the possibility of future diagnosis, should he continue to exhibit some or a combination of the above. Kieron's bedwetting stopped prior to his attendance at school (aged 5 years), and some of the other indicators mentioned are not relevant to Kieron at his young age e.g. theft and truancy, fire-starting. The exact aetiology of psychopathy is still not known, and there have been substantially less research studies focussing on children and adolescents, quite possibly due to the difficulty in diagnosing mental disorders amongst adolescents. Some normal features that accompany adolescence resemble anti-social tendencies, e.g. mood instability, defiance and anger management, and so might easily be mis-diagnosed. Empirical findings from recent research into the question of whether young children with early indicators of psychopathy respond poorly to intervention, compared to conduct disordered children without these traits, were consistent with broader anecdotal evidence i.e. poor treatment outcomes (Hawes & Dadds, 2005).

Psychopathy, which is mainly associated with anti-social personality disorder (which Big Kieron had been diagnosed with), is also seen to be linked with conduct disorder in children and ADHD. Dr Katherine Ramsland, forensic psychologist, speaks of the muddling of concepts and diagnosis (Ramsland, 2010) and of how psychopathy and conduct problems are independent yet interacting constructs in children, similar to the way criminal behaviour and psychopathic personality traits interact in adults (e.g. glibness and

manipulation). She states that the most significant traits for psychopathy are grandiosity, irresponsibility and susceptibility to boredom and points out that these traits are also linked to children with conduct problems.

Donald R. Lynam has carried out extensive research work in this population (Lynam, 1996, 1997, 1998) which demonstrates that psychopathy has a strong common ground with ODD, CD, and hyperactivity. He believes there is a neurological deficit that manifests as a lack of behavioural restraint, as is found in hyperactive and impulsive children. Those with psychopathic personalities were shown to be stable offenders who were prone to the most serious offenses. Childhood psychopathy has also been shown to be the best predictor of antisocial behaviour in adolescence. Lynam advocates the need for continued research in this area to explore the concept of childhood psychopathy so that it can be measured more consistently and consequently provide an improvement in predictive outcomes.

Lynam also tested a hypothesis about the relationship between the adult psychopath and children with cluster symptoms of hyperactivity, attention deficit, and impulsivity (HIA), and concurrent conduct problems (CP). Dividing a population of adolescent boys into four groups: non-HIA-CP, HIA-only, CP only, and HIA-CP he compared on measures thought to determine psychopathy. As he predicted, the HIA-CP boys most closely compared with psychopathic adults. From the four groups studied, this group were the most antisocial, disinhibited and neuro-psychologically impaired i.e. those who had attention deficits and poor impulse control associated with conduct problems were more likely to manifest traits of psychopathy.

## **Child Psychotherapy and Psychoanalytic Research**

In contrast to the approaches discussed above in which I have sought to define ADHD in medical terms, drawing on biochemistry, and to approaches which have examined the broader social context in order to understand both these behaviours (Panksepp, *ibid*) and their theoretical construction, (Hacking, *ibid*), there are the perspectives of psychoanalysis and child psychotherapy. These are concerned primarily with the role of early primary relationships in the development of personality structures and behaviours, both through the continuing direct effects of relationships with parents, and through the lasting 'internal' or unconscious consequences of early relationships. The evidence on which these approaches draw tends to be primarily that of clinical experience, usually reported in case studies.

Mary Boston and Rolene Szur (Boston & Szur (Eds), 1983) in their book entitled *Psychotherapy With Severely Deprived Children*, gather together individual case examples of just over eighty children with severely deprived backgrounds. The concept of the "fighting spirit" is described and associated in this study with being alive as opposed to an "emotional deadness" in response to their personal plight. At one time, these children were also thought of as not suitable for individual psychotherapy. The efficacy of child psychotherapy on the internal world of these young people is demonstrated within this book, and led to a broadening of thinking around who might reasonably access psychotherapy.

As mentioned, ADHD is not the usual choice of therapeutic input for children with ADHD symptomology (NICE Guidelines, 2008). There are as yet no larger-scale systematic studies of ADHD based on a psychoanalytic perspective, for example in regard to the efficacy of psychotherapeutic treatment for these conditions although it is possible to imagine that outcome studies recently and currently being conducted in severe depression (IMPACT study) could provide a model for the investigation of other conditions, such as ADHD.

In the book *"Rethinking ADHD – Integrated approaches to helping children at home and at school"*, the authors state that:

*“if we are to place the exploration of ADHD within the broader context of the child and family public health domain, then it forces us to adopt a new model of thinking – a new paradigm, one that enables us to integrate our knowledge of the physical workings of the brain with our understanding of the psychological and emotional development of the mind.”* (Neven, R et al 2002, p10)

The authors point to the tendency in the sciences towards specialisation, arguing that this has decreased communication between the disciplines, and they point to the lack of dialogue within psychology itself e.g. between neuropsychology and psychotherapy, and the detrimental effect this has on the patients they are both aiming to treat. The authors indicate that from a psychodynamic approach *“all behaviour has meaning and is a communication”* and further that once this tenet is understood, we are able to view attention not simply as a cognitive activity but primarily as a relational response that emerges out of the earliest attachment and bonding experiences between the child and their parents. Further, that *“early relationships from our infancy and childhood shape our future”* due to the fact that we are prone to repeat our previous behaviours. From a psychodynamic viewpoint, we are concerned with examining not only the external symptoms, but also the underlying, unconscious processes at work internally.

Elizabeth Cleve’s successful once-weekly work with an adopted boy Douglas who had severe psychic, physical and social handicaps plus a diagnosis of ADHD is documented in her book, *From Chaos to Coherence* (Cleve, 2004). She met with Douglas for psychotherapy over a period of 7 years and states that in her experience, many children have a combination of both emotional and neuropsychiatric disturbances that contribute to aggressivity, hyperactivity, and lack of concentration. She stresses that each child needs to be worked with psychotherapeutically according to their individual need. One of the arguments against psychotherapy for children with ADHD is that it is too expensive, but one might easily ask, how can

we afford not to provide this service, when evidence suggests that in the long term these children will be far more of a financial burden on society (see Slater, 2009 below).

Jan Anderson (Anderson, 2001) in her doctoral thesis entitled *Risk Taking Dangerous Behaviour in Childhood*, and her paper entitled *Mythic Significance of Risk Taking, Dangerous Behaviour*, (Anderson, 2003), makes reference to the clinical presentation of three havens in children where there is insufficient containment: no haven, illusory haven and perilous haven. She suggests that these containment forms are connected to different configurations of the Oedipal relationships. Anderson's findings seem very relevant to the case discussed in this thesis. It seems to me that Kieron belongs to the Perilous Haven category proposed within her research. Both of Kieron's parents (particularly mother, father was incarcerated) were pre-occupied with their own concerns, mother experienced and described Kieron as unmanageable. He was definitely the object of her open hostility and the recipient of her intrusive hostile projective identification, which Kieron readily acted out through his aggressive, dangerous, and psychopathic behaviours. Kieron was threatened by mum and so was unsure what type of reaction he would receive from her.

One of the other points raised by Anderson is that of the parents wanting or seeking an '*illness label*' such as ADHD. There seems to be a link here between Anderson's paper and Pozzi's paper entitled *Ritalin for Whom?* (Pozzi, 2000) in which Pozzi describes how parents renounce awareness that family events, parental tensions, attachment difficulties, traumatic events or similar problems affect their children. The problem is therefore viewed as being securely located inside their child. It seems to me that the prescribing of Ritalin by the psychiatrist reinforces and compounds in the parents' mind the idea that the psychiatrist also agrees with this formulation. The prescribed drug therefore not only relieves the parents of an unbearable guilt but also frees them of responsibility, and consequently denies them the opportunity of thinking and connecting up their child's behaviour and their own involvement in their child's problems. The responsibility is projected onto an outside authority – in this case the prescribing psychiatrist. At this point I would like to mention that the pressure that is exerted by some parents onto the prescribing psychiatrist can



be quite considerable. Pozzi (Pozzi, 2000) notes the rise of a culture in which complaints and litigation are not uncommon, and states that professionals may feel pressed to provide treatment which they do not always have much confidence in.

There are of course, parents who are at the other end of the spectrum. Eileen Orford (Orford, 1998), likens the childhood experience of ADHD to that of:

*“Being tossed by the waves and being at the mercy of the whirlwind, and of not being able to cope with life and themselves”. (Orford, 1998),*

She speaks of worried parents’ relief that the problems they experience with their child are understood by others, and the gratitude they can feel for a medical diagnosis with a pharmacological treatment. Orford also mentions that this shared acknowledgement of a diagnosis may be a reason why ADD/ADHD is over-diagnosed. She urges that when children show some of the signs of these disorders, that each child’s situation is attended to and understood individually. Orford outlines case examples of her work with individual cases, and the positive outcomes that have been obtained through individual psychotherapy. Jones & Allison, (Jones & Allison, 2010), point to the feelings of frustration and despondency that parents feel about their parenting capacity when faced with their deteriorating relationship with their child. These feelings are directed towards the health care providers in an urgent, desperate, ‘solve it’ manner. A child with ADHD is often isolated amongst his peers, targeted by his teachers, and constantly being reprimanded at home, one can only wonder, where is their refuge?

Schore, (Schore, 1994), in his paper entitled *Affect Regulation and the Origin of Self*, speaks of the mother’s role in the neural underpinning of the infant’s capacity for self-regulation as the brain continues to develop after birth, and of how this development depends upon interaction within the facilitating environment i.e. between the baby and its mother. Bion, (Bion, 1962), stated that it is vital for a mother to be able to contain her infant’s unmanageable feelings, and respond to her infant in such a way as to acknowledge their distress and simultaneously contain their helpless feelings i.e. help their infant to manage what they felt was unmanageable. It is a soothing response that the

infant desires, and this soothing enables the child to take back his anxieties in a much more digestible form; he is soothed, and all is well in his world once more.

Shuttleworth's (Shuttleworth, 1989) article entitled *Psychoanalytic theory and infant development*, discussed how an infant requires the intervention of a more mature personality for its development and how:

*'the experience of being held, fed, looked after and talked to is internalised by the baby enabling him to maintain a sense of being gathered together, and to attend to the world around for increasing lengths of time'.* (Shuttleworth, 1989)

I believe that the symptoms of ADD/ADHD may describe the disruption of the internal world of an infant when it is not fortunate enough to have this experience with its mother or care giver. When the sense of *being gathered together* is absent the infant may experience this lack as something akin to a trauma i.e. a life threatening experience. Perry, (Perry et al, 1995) found that ADD/ADHD symptoms closely mirror those that occur during trauma i.e. the hyper-alertness, the need to act quickly, be constantly 'on the go'. They have hypothesised that in a critical period in infancy some children with a diagnosis of ADD/ADHD had experienced trauma, which had initiated a habitual set of automatic responses. They suggest that the child's established neural pathways responded to current situations as if they were a potential threat and trauma occurring in the present. Gilmore, (Gilmore, 2000), states that early trauma should not be seen as surprising in these children and he describes ADHD as "just a set of behavioural, emotional, and cognitive symptoms that indicate an underlying disturbance in the synthetic organising and integrative functions of the ego". Alan Sugarman (Sugarman, 2006), emphasises that children with a diagnosis of ADHD:

*"Have serious problems with self regulation because affect regulation, narcissistic regulation, and stability of self-and-object representations are problematic. Consequently their minds have difficulty balancing and maintaining a homeostatic equilibrium between the many mental processes and contents necessary for adequate self-regulation".* (Sugarman, 2006)

His findings also point to an alternative way of working with children with this diagnosis; which does not simply rely on the use of psychostimulants. That is, through the use of child psychotherapy, one can attempt to help develop within the child a different, 'normal' neural pathway. Anderson (ibid) points to the already overstretched child services with the NHS that are catering for an ever increasing demand for prescriptive remedies despite the decrease in resources available. Within CAMHS currently, posts are being frozen or disappearing completely due to cutbacks and this will only add to the existing lack of services available for children with ADHD. Increased pressure will be put upon psychiatrists to prescribe, and this will I believe, only seek to accentuate the prescribers' own unconscious ADHD type reaction to the presenting problem i.e. they may feel compelled to prescribe, in order for the pressure exerted to be relieved, without due consideration for the consequences of their decision. (See page 145 below). Anmarie Widener (Widener, 1998) speaks of the highly subjective nature of the ADD/ADHD diagnosis, and states that the so-called 'symptoms' refer to a child who is acting out in some way behaviourally. Further, the oversimplified 'solution' of giving a pill is far easier than considering the dynamics that underlie the child's presenting behaviour.

Sugarman (2006) suggests that psychoanalytically informed treatment of these children be carried out on two fronts: the first being sensitive individual treatment to overcome their self-regulatory problems, and secondly an intervention that would address the traumatising socio-cultural setting to prevent the trauma from repeating itself and from undermining gains achieved from treatment. At the 46<sup>th</sup> Congress of the International Psychoanalytical Association held in Chicago, USA in July 2009, a panel set up to discuss "*The Convergences and Divergences in Treatments of So-Called ADHD Children*", Professor Marianne Leuzinger-Bohleber attributed the growing discussion of ADHD by psychoanalysts as a response to competition from other treatment modalities – principally Cognitive-Behaviour Therapy and Psycho-pharmacological ones. She emphasised that psychoanalytic concepts offer the possibility of shedding light on "*the complex and multiple determinants of ADHD*". She saw this as heralding the possibility of a more differentiated diagnosis and treatment strategy that would accept and incorporate the

likelihood of different psychodynamic sub-groupings of children, who might otherwise all receive the same descriptive diagnosis of ADHD. Psychoanalytic retrospective studies indicate that the tolerance of the primary attachment figure towards the baby's outbursts, as well as the mother's ability to soothe, hold and 'contain' the outburst, play a key role in the origins of ADHD (Leuzinger-Bohleber et al, 2010).

Similarly, Salomonsson (Salomonsson, 2004), has advocated psychoanalysis as an important alternative, in addition to the pedagogic and pharmacological measures that might be needed, for children with ADHD. In 2006, his research into the impact of words on children with ADHD and DAMP (Disorder of Attention, Motility Control and Perception – used mainly in Scandinavia) indicated these children are highly sensitive to the analyst's interventions. This he explained as not always being due to the literal meaning of the intervention, but the way the analyst's words are perceived and felt by the child. He observed that *"the children sometimes reacted as if the words were dangerous concrete objects, which they must physically fend off"*. He suggests that this phenomenon relates to the child's *"unstable internal situation"* and that the child's bad, un-containing internal object is easily awakened and reacts by threatening to expel the analyst's words as a defence against the perceived danger. He argues that infant research and psychoanalytic work with infants and mothers demonstrates how a complex semiotic process develops between mother and baby, and he draws on the importance of a secure external object that can be internalised by the child as a prerequisite for this process to develop. Child Psychotherapists can offer such an external object which hopefully can be gradually internalised by the child where there has been an external containment failure and consequently an internal containment failure in the child which has resulted in their ADHD behaviour.

Jones & Allison (ibid), postulate that Child Psychotherapy has a role to play in helping children with ADHD by promoting super ego function - in response to what Barkley (Barkley, 1998) refers to as their deficit in inhibitory control.

*"we do not tell the child off for their impulsive, hyperactive and inattentive presentation, but promote qualitative verbal representations of*

*experience that the child can use to establish themselves within a context, with a self that is heard and a history that is understood” (Jones & Allison, 2010).*

They list the psychotherapeutic processes of *‘identification, introjection and internalisation’* as antidote to Barkley’s (Barkley, *ibid*) contention that ADHD children are unable to optimally use their ‘executive functions’. They propose that child psychotherapy has a role when medication is used (to ensure that any use is adequately framed for the developing ego), and as an alternative when medication ceases to show that clinical benefit. They also suggest that it might be prudent to offer early aid to the young child’s developing ego: it would better be able to manage its struggle with the demands of external and psychic life (including notably the aggressive instinct).

According to The Office of National Statistics findings (2006), children today are 3 times more likely to be part of a single parent family than in 1972. Only one tenth of all children living in single families live with their fathers: the remainder, over 2 million reside with their mothers. There may be a significant link between single mothers who are unable to cope with the pressure of being a single parent and the impingement of their deprived social situation on their ability to parent their child. This may be a contributing factor to the increased number of incidences of reported ADHD from mothers – it may also of course reflect their deprived financial situation following the loss of a male role model within the family, and their incentive for accessing their rightful extra financial support.

Kieron in this thesis, had thrown a hamster against a wall until it was dead, drowned one family kitten and would possibly have drowned a second had he not been restrained, at age 3 years. Harding 1998:1 cites findings from the Institute of Policy Studies, which suggest that 50% of all criminal offenders are under the age of 21 and that:

*“Persistent offending has its roots in disruptive behaviour that can be detected as early as 3 years” and that “life experiences continue to influence whether anti-social behaviour persists or desists after childhood”*

Peter Slater in his doctoral thesis (Slater, 2009) entitled “*A boy afraid of his shadow*” examines how the experience of having a violent father impacted upon a latency boy’s development and search for identity. In this study, Slater (2009) sites CIVITAS – The Institute for the Study of Civil Society – findings that children living without their biological fathers are more likely:

- To live in poverty and deprivation
- To have emotional and mental health problems
- To have more problems in school
- To have difficulties in relationships, for example demonstrating hostility to adults or other children or being destructive of belongings
- To have a higher risk of health problems

Mealey (Mealey, 1995) argues that twin studies reveal a ‘substantial’ genetic effect on criminal behaviour and later Pinker’s (Pinker, 2002) accent on genes as a major basis of aggression, criminality or anti-social behaviour also confirms this link:

*“There can be little doubt that some individuals are constitutionally more prone to violence than others; men, for example, and especially men who are impulsive, low in intelligence, hyperactive, and attention-deficient”*  
(Pinker, 2002)

Evidence that childhood aggression is a precursor for adult criminality (Pulkkinen & Pitkanen 1993: Denham et al, 2000) are cited by Gerhardt (Gerhardt, 2004) as perhaps confirming the geneticists’ belief in the importance of innate factors. Cadoret (Cadoret et al, 1995), a behavioural geneticist has also found that children who had anti-social parents had a greater probability of becoming anti-social, even if they were adopted into a different family. The research listed above does sound pretty definitive evidence of the genetic roots of violence and criminality. However, it is universally agreed by geneticists and researchers alike, that there isn’t a genetic code for defining social behaviours. Perhaps most significantly, Gerhardt (Gerhardt, *ibid*) points out the important fact, that the research findings omit the importance of the experience of

pregnancy and the first year of life in shaping human behaviour – something that child psychotherapists have known and demonstrated to be vital for future outcome prediction.

From the above discussion, it can be seen that there is a deep gulf between the different explanatory languages and models used to describe and explain ADD and ADHD in the literature. This resulting conflict and confusion does not help Child Psychotherapy as a profession. One of the difficulties this gives rise to is that although Child Psychotherapists may be seen to understand the meaning of a child's behaviour, inner world and the anxieties that give rise to it, in a plausible and convincing way, the underlying models which inform their understanding are not recognised as having scientific validity by professionals from other disciplines.

In my own clinic I am fortunate that my co-workers welcome psychoanalytic ideas and psychotherapeutic input. I currently am seeing two boys with ADHD for once weekly psychotherapy which runs concurrently with their Ritalin medication. Their response and improvement to psychotherapy has been much appreciated by the grandparents who are their main caregivers, and the prescribing Psychiatrist. Recently I have been approached by two of my psychiatric colleagues to offer insights about the effectiveness of classroom observation of children with ADHD, with a view to having a paper published in a psychiatric journal. They have found that by having an observer in the class room, whether it be the head teacher or the psychiatrist, somehow skews the observation – the children show little or no ADHD symptomology and they are uncertain how this can be. I have discussed with them the importance for ADHD children of having a strong, authoritative, boundaried mind that can think about them, and be present for them. The presence of these strong figures in their vicinity appears to counteract the children's own lack of internal regulation. The parental function in their mind is somehow complete. It does of course raise the point that if this function can be so easily evoked by the presence of another with authority, then might it also not be evoked spontaneously by the child if they were to encounter this presence on a regular basis i.e. through Child Psychotherapy as in this case of Kieron.

## **Methodology**

The clinical case study has been the most widely-used form of clinical research in psychoanalysis to date - using both single case and comparative case-study methods - and it is the former method that I will be using in this thesis. In this chapter, I will be outlining some of the current theories surrounding the single case study as a qualitative method of research and I will then be discussing how this systematic method was used for this particular piece of research.

### **Case Study Methods**

#### **Advantages of the Single Case Study Method**

The case study method attempts to describe a whole configuration of attributes within a given boundary – this can be an individual personality, an organisation, an event, etc. It is important to recognise that case studies can produce extremely detailed, layered and informative insights which can access the individuality, creativity, innovation and broader context of the particular case in question. It is by capturing the full descriptive detail of the case study that it is possible to establish what relations exist, both internal to the case being studied, or with elements outside it.

The compiling of detailed case histories was considered an indispensable tool of physicians from the time of Hippocrates. It only fell into disrepute in the twentieth century and were dismissed as being merely “anecdotal” evidence in favour of generalised data. Accompanying this discrediting of case studies was the fact that medicine, having been largely powerless in the face of most diseases, found a large repertoire of effective treatments. Epidemiology e.g. the causal association of diseases with infective agents like waterborne bacteria, made a huge contribution to human health. Even in psychiatry, drug therapies have made many disorders relatively manageable, as they were not previously. What was lost in this ‘evolutionary’ process was the sharing of the stories of patients’ inner lives. When patients recover their own story by telling another in confidence, this interaction is in itself healing, and might be referred to as a ‘*romantic science*’ (Luria, 1968), it prepares them for transformation. This transformation can be witnessed in therapy, e.g. when a patient has a



particular insight and understands something hitherto hidden from their conscious awareness. These incidences can be documented as plausible scientific evidence and can be used to give insight into how the mind works to others<sup>1</sup>.

One of the main sources on case study methods is provided by Stake, (1994) in *"The Handbook of Qualitative Research"*. In his chapter entitled case studies he outlines that the case researcher seeks out both what is common and what is particular about the case. He notes that the end result is that they regularly present something unique, and that this uniqueness is likely to be pervasive and extending to:

- 1 The nature of the case
- 2 Its historical background
- 3 The physical setting
- 4 Other contexts, including economic, political, legal and aesthetic
- 5 Other cases through which this case is recognized
- 6 Those informants through whom the case can be known

As a form of research the single case study is defined by its specific interest in individual cases, not by the particular methods of inquiry used (Stake, 1994) (as cited in Denzin & Lincoln, chapter 14). Single case studies with different objects of study (e.g. psychoanalytic therapy, or the behaviour of particular kinds of organisations like schools) will necessarily employ different methods of data collection and analysis. The single case study draws attention to the question of what *specifically* has been learned from the single case in question and its focus is the understanding of the individual case, rather than a generalised overview.

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<sup>1</sup> "a case study is generically a story; it presents the concrete narrative detail of actual, or at least realistic events, it has a plot, exposition, characters, and sometimes even dialogue" (Boehrer, 1990).

The case study, as already mentioned, is an exploration of 'a bounded system' (Smith, 1979). It is not studied primarily to understand other cases, its aim is to understand just one case (Stake, 1995), although this would not preclude the single case study from being of value when trying to understand other similar cases. It is qualitative and it is based on naturalistic (subjective) observation as opposed to a controlled experiment – although not always.<sup>2</sup> Freud stated that cases that are devoted first to scientific purposes:

*"...Suffer in their outcome; whilst the most successful cases are those in which one proceeds as it were, without any purpose in view, allows oneself to be taken by surprise by any new turn in them, and always meets them with an open mind, free from any pre-suppositions (Freud, 1912)*

Freud believed that the unconscious mental life needs to be allowed space to manifest itself.

Damasio (Damasio, 2000) in his outstanding book, *'The Feeling of What Happens'*, details through illuminating neurological single case studies, how our consciousness, our sense of being, arose out of the development of emotion. Another professor of neurology, Oliver Sacks (Sacks, 1985), presents *'the patient's essential being'*. He states that it is here that the patient's personhood is essentially involved, and the study of disease and of identity cannot be disjoined – he names this study as the 'neurology of identity'. His material evokes the traditional way of recounting patients' tales in a way that is both informative scientifically and interesting generally – bringing together fact and fable. I cite these authors to show that the clinical case study is taken seriously as a method of research by neuroscientists and not only by psychoanalysts.

Case studies characteristically examine the interplay of all variables in order to provide as complete an understanding of an event or situation as possible. This type of comprehensive understanding is arrived at through a process known as 'thick description' (Geertz, 1973), which involves an in-depth explanation of the

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<sup>2</sup> See below Winnicott, 1958 p. 8 and Main, 1985, Ainsworth *et al*, 1978 p. 9).

individual being evaluated, the circumstances under which the description is applied, the characteristics of the people involved, and the nature of the community and their location. Geertz reasoned that 'thick description' is necessary because human beings make their own worlds through shared cultures and meaning.

What transpires is a "deep listening", whereby the subtle harmonies and disharmonies in the patients' behaviour are heard and acted out. Geertz's term was originally used when referring to ethnographic work in anthropology, and not in single case studies, but in his book entitled "*Local Knowledge*" (Geertz, 1983), he does make a link between the two.

The single case study allows the researcher the freedom to discover and address issues as they emerge from experience with a specific individual or an individual organisation, social group etc. One of the greatest opportunities that the single case study affords is the prospect of commencing with a very broad question and narrowing the focus as the process of analysis unfolds and develops. Both prescriptive and predictive methods are concerned with establishing a replicable set of data but are not so concerned with the differences which so obviously occur within the individual instance i.e. they are not replicable, they are unique, but perhaps have some similarities that might be usefully analysed to make a contribution to the body of knowledge in a particular area. The single case study (whether of a human individual or a group process), is concerned with those respects in which the particular person or case is unique, though it is also attentive to the discovery of attributes that might be the basis for generalisations to larger populations. It is the understanding of the individual and the conveyance of this understanding to the reader that is paramount in the single case study. The understanding of a particular case study in depth affords the hypothesis reached to be applied in situations which are similar but not identical. Rom Harré (1979) has argued against the grain of mainstream psychological research that more original scientific discoveries have been made through 'intensive' than through 'extensive' (i.e. quantitative) studies. This is certainly the case in the field of psychoanalysis thus far.

## Limitations of the Single Case Study Method

Quantitative methods on the other hand - statistical methods among them - abstract from particular descriptions particular attributes or variables, and then these are used to see how these correlate with one another. Their aim may be mainly descriptive (e.g. to set out the incidence of a phenomenon) but they often aim to discover causal relationships of greater or lesser complexity. One of the main criticisms directed towards the single case study as a research method is that it is not considered to be scientific when it is compared to quantitative analysis.

Stake (Stake, 1994) states that case study methodology has suffered damage because *“the researcher’s commitment to generalize or create theory runs so strong that their attention is drawn away from features important for understanding the case itself”*. Campbell (Campbell, 1975), states that the case study can usefully be seen as a small step toward grand generalization.

A distinction can be drawn between single case studies, which was the method used in this research, and multiple case studies where it possible to compare cases and their similarities. This might be, for example, in the initial presenting symptom of a psychotherapy patient, and/or in the method of treatment employed, or family background). These similarities might be sufficient to allow both generalisations to be formulated and tested, and for specific differences in a sample to be identified and analysed. A comparative approach may be part of a specific research design (e.g. Anderson, 2001) or may be retrospectively employed in considering case studies separately conducted, whereby they have many related aspects. The Tavistock’s ‘clinical workshop’ method of research (Rustin, 1999) has been a prolific method of research of this kind, giving rise to valuable findings in areas such as fostering and adoption, autism and borderline states.

The advantage of the use of multiple comparative case studies over single case studies is that they allow for emerging hypotheses to be tested in relation to more extensive evidence. This makes it less likely that a research will become over- committed to particular ideas formed in the absence of any suggested alternative. Despite the fact that multiple clinical case studies are unlikely to

meet statistical criteria of significance and representativeness where sample sizes are small, they can provide a reality check which is larger than a single clinical case study might ordinarily provide. My study, however, arose from the presentation of a patient in a clinical situation, and it will only be possible for me to compare my findings with other comparable cases in retrospect, should case reports or case material on work similar to mine become accessible to me.

An alternative to case studies is the testing of defined hypotheses through experiment or controlled observations. This is what most empirical psychologists try to do. The question is why have psychoanalytic psychotherapists hitherto not mainly proceeded in this way? The reasons seem to be:

- (1) that the population they are interested in is too diverse to allow the selection of standardised samples for investigation (though studies like the Impact Study are now trying to address this – see below)
- (2) because the method of treatment cannot be unduly standardised in advance of its practice, since its efficacy depends on free exploration of what emerges from the therapeutic process

While this may not be at all tidy or predictable, it is justified because what needs to be accessed and understood – unconscious mental processes – cannot be readily accessed in more pre-structured ways. (There are other methods e.g. the Story Stem, which do try to combine sensitivity to unconscious material with standardised measures. (Minnis H et al, 2006)).

One criticism of case study methods detailed by Cooke & Campbell (Cooke & Campbell, 1979), speaks of clinicians using the case report as a way of attributing positive outcomes to the effects of their own clinical work, without taking into account any other influences, thus threatening the validity of statements made from the correlation between the therapy and the observed changes. Support for this viewpoint was expressed by McGuire (McGuire, 1983), when he stated that a researcher with “*sufficient stubbornness, stage management skills, resources and stamina*” would undoubtedly find or construct a context in which the predicted relationship will “*reliably emerge*”.

Another criticism of the single case study method is its reliance on anecdote and narrative persuasion, and a reliance on a singular explanation (Spence, 1993). The cases usually only reflect chosen aspects of the clinical encounter, and could be regarded as biased and too 'tidy'. A reader would be unable to formulate whether the interpretations used and the explanations given could be other than what they are set out by the clinician to be, whereas reports usually contain evidence that can only be explained in one way and are therefore deemed to be far more specific. Rom Harré argues that 'intensive' studies have always been more important in science than 'extensive' studies, saying that laboratory studies are in a sense 'single case studies' under controlled conditions' (Harré, 1979). Sayer, appears to concur with this, and states that:

*"Extensive studies are weaker for the purpose of exploration not so much because they are a "broad brush" method lacking in sensitivity to detail, but because the relations they discover are formal, concerning similarity, dissimilarity, correlation and the like, rather than causal, structural and substantial"* (Sayer, 1992)

Spence (Spence, 1993), postulates that what therapists determine as 'facts' are in fact ambiguous to the reader. He states that the facts in the case study are *"knowable pieces of reality "out there", which guide the reader in a particular direction"*. Seen in this light, the reporting of the case study has important implications for the progress of psychoanalysis as a science. If reports are anecdotal, selective, consciously and unconsciously self-serving, and biased toward a single solution, then psychoanalytic literature is at the very least incomplete. He also alleges that the case study genre tends to *inflate the status of prevailing theory* - through the picking and choosing of material by the recorder. On a more positive note, he does also suggest that case-study reports could be improved if the 'raw data' were separated from theoretical interpretation, e.g. if transcripts could be made available in full. To avoid the therapist from skewing her findings, (Greenwald *et al*, 1986) have suggested that researchers study the *pattern* of significant behaviour and to understand how a particular happening may emerge in the context of the observation.

Single case studies might be merely considered to be description of analytic technique, and not the objective facts:

*“Such monographs prove nothing, but rather offer any willing person the opportunity to share an experience...Experience-sharing does not constitute scientific proof” (Widlöcher, 1994)*

The hypotheses put forward in case studies should be supported by substantiated fact and the clinical research material of the present study does provide for this; the process notes were read and more ideas and insights have been added via supervision notes, and notes and ideas that the author has had since the end of the treatment. It is true to say, that not ‘everything’ that transpires in the clinical setting is included – how could it be? But the idea of the no-fault exclusion i.e. what is omitted making “little or no difference in understanding” is quite appropriate I feel (Spence, 1993).

*“Not only are we being continuously deprived of salient facts, but the facts reported and the interpretations placed on these facts tend to conform to the prevailing zeitgeist because the case study genre tends to inflate the status of prevailing theory” (Spence, 1993).*

This quotation represents a challenge to the method presented in this thesis, and I would respond by saying that the relationship formed during the therapy is of the utmost importance, subjective as it is. Who decides what is a salient fact is also in question here. In my opinion to be aware of the ‘salient facts’ one would have to be present in the room as an observer to decide what the observer feels is salient. This is in itself an impossible notion, and would not necessarily help the observer to gain the same insight as the therapist present. The relationship and attunement built into the therapeutic relationship is not something that can be absorbed by a third party, it is something that is experienced in the room by the two people involved. I would add that should the patient be seen by another therapist I would be very surprised if their interpretation of the material presented in a session were to be the exact interpretation that I offer in the phases presented in this thesis. I would also suggest that I have not sought to inflate any existing theories in this research material.

The guidelines through which the therapy is directed and the clinical setting provides a clear structure, and where these are adhered to, the resulting transference will be clearly evident. One issue is, how can changes in a patient be directly linked to therapy when external influences might so easily also be influencing change - (e.g. natural development (adolescence) and life changes, change of residence). This and the fact that the therapy is subjective, i.e. is understood from the therapist's viewpoint, are what I consider to be two of the limitations of the clinical case study method I have used.

### **The Single Case Study Use in This Research**

I have chosen to use the case study method as it is a comparatively flexible method of scientific research. The emphasis is towards description and exploration rather than prescription or prediction. In certain cases where prescriptive methods are used the methodology would be based on outcomes previously proven to be effective and where predictions based on established scientific theories are being tested it might almost be a foregone conclusion that every patient with the same set of symptoms would be expected to have the same outcome from the same treatment. Many standardised medical treatments might confirm to this prescriptive or predictive pattern. This is not my intention within this thesis. With cases of psychoanalytic psychotherapy, both initial diagnoses and treatment outcomes are usually too uncertain to make possible such an approach; due to its nature it is likely to be more of an exploratory process.

The main reason for adopting a single case study method in this study was practicality – I had extensive records of only one intensive case of this kind, and it was not feasible to undertake other clinical cases for purposes of comparison within the time available for this research.

This case study examines a particular question and aims to find a holistic understanding of the situation using inductive logic reasoning to move from specific observations to more abstract and thus generalising terms. Its endeavour is to develop new understandings, concepts and hypotheses upon which further



research may be built. Whilst appreciating the pitfalls of the single case study as a scientific method of analysing data, the most pronounced being that conclusions and theories drawn are not necessarily replicable elsewhere, it remains the most effective tool in psychoanalytic research today. It has been argued that psychoanalysts and psychotherapists have to move closer to the scientific mainstream if their findings are to have credibility elsewhere, and certainly clinicians working within the NHS setting currently are working under constrictive pressures from management to provide measurable research outcomes and effectiveness of treatment for their patients in a cost efficient way. Peter Fonagy, a contemporary psychoanalyst and clinical psychologist, who recognises these changes within the NHS states that:

*“Without intense research on the effectiveness of the method deeply rooted in and shaped by psychological models of pathology, the long-term survival of this intervention is not assured”.* (Fonagy, 2009)

Today's climate reflects the drives of commissioners for clinicians to produce 'evidence-based' healthcare for patients, and demands data to support the clinician's claims that psychotherapy is a valuable method of therapeutic input (Rustin, 2009). Psychotherapy, by its very nature is long term, and is often considered to be far more costly as a method of treatment than its more popular counterpart, Cognitive Behavioural Therapy (CBT). However to make such assessments it is really necessary to know what the long-term outcomes of each treatment are. Currently there is insufficient evidence to know whether child psychotherapy is more cost effective than CBT; however, there is a forthcoming study that will be able to provide more substantial evidence in this area. This is the IMPACT study which will examine a specific kind of psychopathology, namely severe depression.

(See <http://www.ucl.ac.uk/psychoanalysis/research/impact.htm>)

I have concentrated in this thesis on presenting in psychoanalytic terms an informed outline of the internal world of an individual; drawing out what makes this case special and interesting. Here it is used singularly, but may also assist in the recognition and understanding of similar situations in other individuals, even though such generalisation was not the immediate purpose of the study. It has

primarily been an exploration into the individual from the clinical perspective, with the hope of enhancing and expanding current thinking in a particular area; namely ADHD. By formulating concepts and hypotheses that explain its development, I hope to provide resources for others to reflect upon in similar cases. A single case study by its very nature gives rise to ideas which might be found to relate to other clinical instances. The point is not that a case study is for the individual's own sake (unless one is describing its clinical purpose), but that it is from the depth of understanding one gains of an individual that one develops concepts that will then have application to other individuals of similar kinds. I believe that the psychoanalytic process provides inimitable access to unique data of how a particular individual changes that may not be accessible outside of the long-term, intimate and confidential relationship that develops over time.

In response to the criticisms aimed at single case study research, I would say that it is possible to separate records of observations or clinical processes from theoretical interpretation of them, and to provide such evidence when offering such interpretations. This is the method that has long been adopted and developed at the Tavistock Clinic where the writer trained. It is also possible to audio-record sessions to ensure verbal accuracy – although this was not something that the Tavistock encouraged its students to undertake during their training. The clinical training that the author undertook has tried to avoid the worst failings of psychoanalytic methods that Spence has drawn attention to, and that – I understand – is the reasoning behind the training methods i.e. to analyse clinical sessions in such detail and to gain further insight through supervision, individual analysis and personal reflection. Also, the further stage of analysis which has been involved through my returning to the case material using a more formal analytic method of grounded theory is also relevant here.

Although different aspects of the conversation with a patient could be focussed upon and taken up, the therapist is primarily led by what the patient brings to the session. The transference and countertransference is monitored in session by the therapist during the session and interpreted as a means of gaining greater understanding of both the unconscious of the patient and their interaction with the therapist.

I am using a case study method because my clinical work has provided some very interesting data which has been derived from a clinical case study, and because since Freud's day, this is the method by which new understanding has been established. More recently, as there has been more interest in formal research methods in psychoanalysis and in other human sciences, understandings have developed of the strengths and limitations of case based research.

What goes on between the participants in any one psychoanalytic setting is very unlikely to be closely replicated by what happens in another. It is extremely hard therefore for psychoanalysts to achieve the level of control and purity that is achieved in scientific laboratories, but I would argue that from a therapist's point of view what takes place in this context is more interesting and exciting than what occurs in most laboratory situations. This is because clinical interaction generates understanding of great complexity and subtlety, more than usually arises from the administering to research subjects of experimental protocols, even though this clinical form of knowledge is more subjective and perhaps conjectural than some others.

### **Case Study Methods in Psychoanalysis and Child Psychotherapy**

The case study, as stated, is an important, valuable method of qualitative descriptive research that can be used to look at individuals, a small group of participants, or a group as whole. Some of the best known psychoanalytic studies have been undertaken using the single case study method:

'Dora', an analysis of a case of hysteria, (Freud, 1901),

'Little Hans', an analysis of a phobia in a five-year old boy (Freud, 1909),

'Rat Man', notes upon a case of obsessional neurosis (Freud, 1909),

'Schreber' psychoanalytic notes on an autobiographical account of a case of paranoia (Freud, 1910),

'Wolf Man', from the history of an infantile neurosis (Freud, 1914),

Analysis of a ten year old boy, known as 'Richard', (Klein, 1961),

The case study has been also been used by other disciplines:

A single community such as Whyte's (1955) study of Cornerville in Boston,

Gan's (1962) study of the East End of Boston,

M Stacey's (1960) research on Banbury,

O'Reilly's (2000) research on a community of Britons living on the Costa del Sol in Spain

A single school, such as studies by Ball (1981) and by Burgess (1983) on Beachside Comprehensive and Bishop McGregor respectively,

A single family e.g. Lewis's (1961) study of the Sanchez family,

A single organisation, i.e. Studies of a factory by Burawoy (1979), Pollert (1981) and Cavendish (1982), or of management in organisations e.g. Pettigrew's (1985) work on Imperial Chemical Industries (ICI), or of pilferage in a single location e.g. bakery (Ditton, 1977) or a single police service (Holdaway, 1983)

A person, like the famous study of Stanley, the 'jack-roller' (Shaw, 1930) using a life history or biographical approach

A single event, such as the Cuban Missile Crisis (Allison, 1971), a vicious rape attack (Winkler, 1995), the events surrounding the media reporting of a specific area (Deacon, Fenton & Bryman 1999) and the Balinese cockfight (Geertz 1973)

The use of the single case study has been generally overlooked and undervalued in psychological circles - possibly because psychologists have cast themselves more in the role of experimental scientists. Child psychotherapists today can no longer rely on the hugely successful demonstrations of intellectual and professional prowess by Freud from the late 1890's onwards, nor the developments made in Britain by using the play techniques developed by

Melanie Klein to keep it afloat. The insights gained from child psychotherapy since this time have undoubtedly influenced the psychoanalysis of adults, and it is to child psychotherapy and its endeavours that we have to look to when trying to understand the new knowledge in child analysis that has been developed since Freud's time (Rustin, 2009).

Recently, child psychotherapists have 'picked up the gauntlet', as it were, and the profession is undergoing dramatic changes as it re-evaluates what it needs to survive in the current day NHS, where a large proportion of child psychotherapists are employed. Rustin (Rustin, 2009) lists in his chapter entitled "*what child psychotherapists know*" the extent to which child psychotherapy has aided adult analysts, and the depth and breadth of clinical knowledge that has been gathered over the past forty years which form the basis of what child psychotherapists know from their own case material. This knowledge has been used to increase the body of literature available through the *Journal of Child Psychotherapy* which is produced by The Association of Child Psychotherapists (ACP), through other journals and books, and to train the next generation of child psychotherapists. The growing number of individual child psychotherapists who have taken up the methodological challenge involved in child psychotherapy research in recent years include Jan Anderson (2003, 2006), Nick Midgley (2004, 2006), Cathy Urwin (2007), Emanuela Quagliata (2008), and Peter Slater (2009).

The honed observational skills, which are employed in the psychoanalytic setting, are crucial for facilitating the detailed observational interpretations of the stream of material content, whilst the therapist is simultaneously being attuned to her own emotional reactions and those of the patient. This I believe negates the criticism that single case study methods are not based on facts: these are clinical facts, (O'Shaughnessy, 1994), closely scrutinised by an expertly trained therapist. The single case study captures the complexity of a particular case and the interrelationships of elements of which it consists. Its scope of application - which other cases are like this, in what circumstances they are found - is something which can then be established and built upon through further research.

What is produced between the therapist and patient is something that is highly individual and personal. It is not purely observational in nature, or merely an attention to feelings. There is an abundance of material which demonstrates quite clearly, the idea of an unconscious mental life, and the significance of the transference and countertransference in gaining access to this. It is the transference-countertransference relationship which provides the context in which the particular kind of observations of self, patient and their interactions which characterise psychoanalysis can take place. Edna O'Shaughnessy (O'Shaughnessy, 1994), in her paper '*What is a Clinical Fact?*' defines clinical facts as those facts that relate directly to the transference relationship that develops between the therapist and the patient. This relationship is one of the factors that are vital for therapy. Rustin (Rustin, 2002) draws the comparison between a scientific laboratory and the consulting room, stressing that it is:

*It is only inside the consulting room that the phenomena postulated by psychoanalysts can be clearly observed and distinguished".*<sup>3</sup>

This is where the creative skills of the therapist comes to the fore – clinical observations and 'experimental interventions' are combined. Their effects can be studied, modified and outcomes observed – maybe even in some instances predicted. The psychoanalytic setting is, I believe, science at its most ingenious. Neither therapist nor patient knows what will emerge or be discovered or even the final outcome.

*"Psychoanalysis has always had its own distinctive research methods, and these have been productive over a hundred years in enlarging the powers of the psychoanalytic paradigm to understand new areas of mental life"*  
(Rustin, 2001)

I am in agreement with the premise that the psychoanalytic situation provides the only situation that can deliver knowledge in this area, but given all the problems of

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<sup>3</sup> See also "*it is of course very difficult reporting fragments of case material to convey this acting out, which after all one mainly intuits from the effect that the patient's words produce on oneself and the atmosphere that is created.*" (Joseph, 1989)

subjective interpretation, seclusion of practice from external scrutiny, 'impurity' of the 'objects' being studied it cannot be called ideal. Fonagy & Miller (Fonagy & Miller, 1979) state that the consulting room can be compared to a laboratory in which there is the opportunity for scientific study (a homogeneous category of phenomena, which can be measured meaningfully). This comparison, they state, holds true, whether the study be patient-based (mood, reflectiveness or cognitive style); therapist-based (empathy or directiveness); or relationship-based (nature of the transference or countertransference).

Winnicott (Winnicott, 1958) developed an experiment involving the observation of babies and how they interacted with a spatula when they came to visit him as a paediatrician. This was a simple, controlled experiment that could be effectively repeated, observed objectively and a hypothesis drawn about anxiety evoked in a set situation. What was gained from these observations was the importance of creating and maintaining a facilitating environment and the importance of this in a clinical setting.

This method is replicated in the clinical setting used by Child Psychotherapists. In the book, *"Assessment in Child Psychotherapy"*, the editorial introduction states that the clinical setting needs to be as simple as possible and to be consistent.

*'Meaning cannot be sensibly attributed to a child's differential response to a therapist between one setting and another if the therapist has altered the setting'.* (Rustin, Quagliata, 2004)

The setting I used was consistent as far as was possible. I say this because during the first year of therapy the clinic in which I was seeing Kieron moved location. There were some differences, some small and others not so inconsequential for the child. All were noted by him and acknowledged by me, and the loss of his special space was thought about and remembered by him well into the second year of therapy.

## Grounded Theory

I have applied grounded theory to my data as set out by Glaser and Strauss in their book *The Discovery of Grounded Theory: Strategies for Qualitative Research* (Glaser & Strauss, 1967). This method of research originally was used in the field of sociology in an attempt to address “*how the discovery of theory from data-systematically obtained and analyzed in social research – can be furthered*”. It has been defined as:

*“Theory that was derived from data systematically gathered and analysed through the research process. In this method, data collection, analysis, and eventual theory stand in close relationship to one another”* (Strauss & Corbin, 1998:12)

Two core features of grounded theory are:

- 1 it is concerned with the development of theory out of data
- 2 the approach is *recursive* i.e. the data collection and analysis proceed in tandem, repeatedly referring back to each other.

Grounded theory thus offers the flexibility of being able to analyse qualitative clinical data through the use of process clinical notes – source material – and the ability to incorporate empirical research and theoretical reflection, making it an ideal method of data analysis in clinical research. This method has been elaborated and developed by child psychotherapists for use in their field, Nick Midgley (2004, 2006), Jan Anderson (2003, 2006), Cathy Urwin (2007) and Emanuela Quagliata (2008).

Glaser & Strauss mention coding the data by the use of noting categories on margins. In this thesis, material is coded on a line by line basis in the commentary. Their constant comparative method rule (ibid, p 106) was relatively easy to sustain in this thesis as codings are recorded in a separate column, which enables previous or similar examples to be more easily identified whilst allowing for free association around the material. From this constant comparison of incidents, theoretical properties of the category are generated. In this thesis, these comparison notes helped to identify the relevant psychoanalytic material that would aid the thinking of that being observed. These are reported in the



discussion following on from the individual case material, these might be seen as the equivalent to the second rule of the constant comparative method - the point where one “*stops coding and record a memo on your ideas*” (ibid pp 107).

The “*integrating categories and their properties*” stage described by Glaser & Strauss occurred in this thesis after all the phases were completed. The phases were then re-read together with the supervisory notes and additional thinking around the subject matter. It was only after this process then that a theme was able to emerge. This took considerable time and what at times felt like monumental effort. It is difficult to allow a space in one's mind for something to emerge without having something predetermined, but this process does, I feel, allow for something unique and creative to emerge. This process would I feel be equitable with the goals suggested by Strauss & Corbin (Strauss & Corbin, 1998):

- 1      build rather than test a theory
- 2      provide researchers with analytic tools for handling large masses of raw data
- 3      help the analyst to consider alternative meanings of phenomena
- 4      be simultaneously systematic and creative
- 5      identify develop and relate concepts that are the building blocks of theory

It is a widely held view that while grounded theory is well adapted for the generation of theories in relation to particular cases, it is poorly adapted to testing the scope of its application. This argument suggests a kind of truce between the protagonists of qualitative and quantitative methods, in which the former (e.g. grounded theorists) are allowed some authority in the ‘context of discovery’ of theories, while to the latter is cede legitimacy in the ‘context of verification’. These distinctions overlap in psychoanalytic research between research into the structures and processes of mental life, and research into treatment outcomes, that is to say the efficacy of psychotherapeutic interventions. It is clear that these different research methodologies do each have their distinctive strengths, and it is also a fact that in the present culture of ‘evidence based practice’ quantitative methodologies have an essential role in establishing the validity of psychotherapeutic treatments.

However, I am not persuaded that no valid claims can be made from the findings of grounded theory in regard to issues of efficacy. The process of constant testing of hypotheses as data is analysed, through the constant comparative method applied to individual session material, surely enables confidence to be placed in certain kinds of findings regarding changes achieved through treatment. These changes would need to be sufficiently marked, and closely associated with the treatment process itself. It is from evidence of this kind, not from quantitative studies, that child psychotherapists have come to have found assurance (admittedly following a considerable sequence of case studies) that severely deprived children can be treated successfully by psychoanalytic methods. A quantitative study in that field, such as the current IMPACT study into severe childhood depression, would certainly add another dimension to such understanding but one can acknowledge this and wish to see such studies, without accepting that we can know nothing about efficacy until such investigations have taken place. Of course, the case study that I present here provides no evidence regarding the longer-term effects of the treatment (e.g. on whether psychotherapy will have enabled the child to avoid the ADHD diagnosis predicted for him before treatment began). The lack of such evidence in this case, however, cannot be solely attributed to the fact that the research was undertaken using a single case study with no quantitative dimension, but might be more because it could not follow the child's development (even via periodic follow-ups) into the period of his later childhood where the longer-term effects of therapy might have been measured. .

### **Data Collection in This Study**

The original clinical work analysed in this thesis took place in a clinical setting in a Tier 3 NHS Child & Adolescent Mental Health Service (CAMHS). The boy, Kieron, was seen three times weekly in this setting. Clinical Supervision was received by me from a Consultant Child & Adolescent Psychotherapist. For the first year this happened on a weekly, face to face basis, and for the second year this happened on a fortnightly, telephone basis. During this two year period the Supervisor was provided with a copy of the detailed session notes and comments were noted by the student. Not every session was recorded fully during the

course of treatment, but at least one session per week was detailed in full. The other sessions were detailed less fully and recorded as part of a computerised logging system. When looking at how many sessions to consider for further analysis all fully detailed, recorded sessions were read through and thoroughly evaluated.

The method of writing up the session notes, coupled with thoughts and feelings from supervision coupled with current ideas is an example of grounded theory in practice. The information is read and analysed and themes do emerge from the analysis that were not in the consciousness of the writer at the time of the original session. This is in part due to the lack of experience and insight that followed from the stage of my clinical training at the time. The starting point and early focus of my therapeutic work with this patient was mainly that of trying to contain and understand him. However both clinical supervision and the research process later allowed more complex understandings to emerge.

Within this study I have drawn on a number of detailed psychoanalytic phenomena e.g. defences, resistance, key conflicts and the manifestation of essential psychological capacities (empathy, control of affects). These have been sampled inferentially, in that they refer to the question that is trying to be answered, based on transcripts of sessions as outlined by Fonagy & Moran (Fonagy & Moran, 1993).

I believe that it is change that is the main aim of the psychoanalytic exchange, this is difficult to evaluate, and an area that is even more difficult to fully expound in a single case study, but as yet, there is no better alternative available. Whilst appreciating the pitfalls of the single case study as a scientific method of analysing data, and the pressures that are put upon clinicians to conform and provide some measurable research material within the NHS work setting (Rustin, 2001), I believe that it remains the most effective tool in psychoanalytic research.

## **Data Analysis in This Study**

Qualitative data in the form of process session notes with supervisory input obtained during the therapy are used in this thesis. Also, thoughts and themes are presented, and then analysed and used to construct theories 'grounded' in the data itself by studying what occurs in this instance within the consulting room. The sessions used in phases 1, 2 and 3 were chosen from data written up over the first year of intensive psychotherapy with a child. The data includes observations – i.e. what was seen, heard, interpreted, acted out, implied, thought, felt, remembered– that took place within the clinical setting. The data is displayed in two columns. The first column shows the detailed session material, the second column contains a commentary. In these phases (1-3) supervisory notes and thoughts that occurred in the writer are incorporated into the second column when reading through the data once more. These thoughts have changed since the original session – the writer having now completed the clinical training, and her own analysis – and so change was to be expected or at least hoped for. I have not included my changing thoughts fully in the material presented here, it would I feel take the reader in yet another direction, and is not pertinent, I feel, to the research purpose of this thesis.

Some of my changing thoughts are however, included in the analysis following on from the original session material. One's awareness and thoughts change over time as they deepen, and only the original material remains static. One could argue that should the writer re-read and analyse the data some five years hence, one might expect and hope that different thoughts and feelings would again emerge, since one might be bringing different theoretical ideas, and a broader comparative experience, to bear on the material. Certainly, having written these sessions up several years ago, it is heartening to find that I can view the same material in a different light.

I decided in undertaking this research that it would not be feasible or useful to systemically differentiate between the understandings I gained through clinical supervision, and my own experience, during the treatment process itself, and those which emerged as I was re-analysing the data for the purposes of this research project. Inevitably, a large part of my understanding of my patient, and

the process of the research, was obtained during the experience of the therapy, which was indeed very intensively and expertly supervised by my clinical supervisor. I can however identify in general terms the additional areas of insight which emerged in the period of research study, when the session material was systemically reviewed.

One of the first things that I was struck by when reading through all the material again, was the improvement that both Kieron in himself, and I as a therapist had made. My ability to manage Kieron within the room had really changed since our first meeting, I had become much more confident in my own ability as a psychotherapist over time, my own personal analysis and clinical supervision had been an enormous help. I had discovered an inner sense of resilience that seemed to have had a profound effect on Kieron and how he related to me. On reading the material it was heartening to see how much progress I had made both personally and professionally, and also how this seemed to be a reflection of Kieron's changes; he was doing well at home and in school, as well as in the therapy room.

Another area of insight came from examining the process notes through the coding exercise. Reading and analysing process notes week by week as I did during Kieron's treatment was very different to reading through his treatment from beginning to end when beginning this research. Instead of focussing on an individual session, reading the whole felt more like a narrative which allowed for differing themes to emerge – the bigger picture - themes that were not apparent during the treatment. Grouping the coded material showed links between sessions in the phases that I had not previously been aware of. In retrospect I can see that at the time of Kieron's treatment I was half way through my psychotherapy training and there were many things that I was uninformed about. Some issues which emerged from the coding exercise had not emerged clearly in clinical supervision. However this seems understandable considering the stage of my training at the time of Kieron's treatment. . This, I believe, is an important observation in that it suggests to me that *“the whole is bigger than can be revealed in the parts”*

I engaged in two kinds of sampling of the material, to make its analysis feasible. The first was to identify four broad phases of the treatment process, defined by change and improvement in the patient's behaviour, and the sustained nature of this improvement. The first three of these phases (process notes from 24.8.06, 14.11.06, 23.3.07, 29.06.07, 13.09.07), were taken from the first one-year period of treatment which this study focuses on. In the account given of these first three phases there is first a lengthy, detailed description, secondly a detailed accompanying commentary, followed by an exploration of the thinking and which I feel are linked to relevant theory in each individual phase. The fourth phase was an attempt to report and understand the material that emerged after the one year period that I am focussing on. The method of presenting this fourth phase differs slightly from the first three phases, but only in the amount of detailed material reported. This fourth phase contains only one full detailed session together with notes about what happened to Kieron over the next eighteen months of our work together. The detailed session material documented was chosen for the richness of its material. It seemed to clearly indicate Kieron's continued improvement and continued development. I hoped in this fourth phase to be able demonstrate the sustained benefit of Kieron's initial first year of therapy. The improvements made in the first year seem to have provided a basis on which Kieron was later able to build.

The second kind of sampling, within each phase of treatment selected, was to identify particular sessions for detailed analysis. Because detailed analysis of session material was essential to my method (and indeed to clinical research more generally), and because of the volume of process notes available (84 sessions in total), I was obliged for practical reasons to select only a limited number of sessions for this purpose. Initially I randomly worked through all the sessions and selected every 10<sup>th</sup> session in sequence. These were read through thoroughly and annotated with the help of preliminary coding. I discovered that I still had too large a sample for detailed analysis, for the purposes of this research. Also, the detail in the random selection of material did not always demonstrate the richness and process that I thought I would like my research to convey. In discussion with my doctoral Supervisor I was recommended to choose the sessions that best exemplified my work with Kieron, and to choose theoretical

sampling – the grounded theorists preferred way of working – in preference to random sampling. I then went back over all the material once more, and selected material that revealed certain relevant phenomena that characterised the work undertaken with Kieron.

In the initial session chosen for Phase One (session date 24.08.06) was selected to give a clear indication of what I was dealing with – a dirty smelly boy, who was physically restless, seemingly without boundaries, regarded as evil, whom everybody hated, and who was, in many ways, psychopathic. These phenomena which I identified as most relevant in the very raw material presented was the epitome of unboundaried chaos. These phenomena are significant concepts in the analysis of the session and show a starting point, from which the other sessions can be compared.

It will be seen that these are significant concepts in the analysis of the sessions presented in phase two and three. For example in Phase Two (sessions dated 14.11.06 & 27.03.07) some of the original concepts are still evident, but there is evidence of a blurring of these in the therapy room. There is a sense that something is shifting, but these changes are also accompanied by Kieron's own resistance. He challenges boundaries yet begins to act with a more thoughtful mind – reflecting the thoughtful mind offered in the room.

Phase 3 sessions (dated 29.06.07 & 13.09.07) were chosen to demonstrate that the original phenomena which I identified as the most relevant from our first meeting had indeed changed. Kieron had become a much more vulnerable boy in the room during this phase, one who was able to think, and question and find some level of acceptance of his painful situation. The initial phenomena were still present, but operating on a much lower level. He had found a way to grow into an amusing, bright, interested little boy, who was no longer a boy to be hated, but a boy to love and be loved.

Deciding which sessions met this aim for my research was a very lengthy process which involved reading thoroughly the process notes from all of the sessions and highlighting incidences of change and adding to these notes my thoughts and feelings that arose whilst re-analysing the material. These were collated and re-read and selected for their richness and ability to convey to the reader the efficacy

of the process. It was difficult to choose particular sessions from the wealth of quality material that I had documented of our work together. I opted for those that I felt best demonstrate to the reader the internal struggle that Kieron had moving through the Phases. He did not suddenly move into Phase Two, and then into Phase Three – there are parts from his original presentation still evident in Phase Three, but there was also in Phase Three a shift towards something far more rounded and wholesome .being evidenced in the therapy room.

The methodology used can be described as systematic in the sense that each session that is recorded fully was written up as soon as possible following the child's session. These were then given to a supervisor prior to supervision and brief notes of their thoughts were written down for future reference – and this is used as part of the commentary. At one of the joint meetings held with both my doctoral thesis supervisors, it was suggested that it might be helpful to arrange the data into phases in order to demonstrate the different developmental stages observed of Kieron during his treatment. The phases chosen are not merely chronological in nature; the sessions chosen demonstrate the progress made during each particular phase. I agreed with this suggested change from my supervisors – as well as with many others gained over the long period of supervision whilst writing this thesis. The phases emerged as a means of drawing attention to each stage of observable development. Sessions were then chosen from the detailed recorded data available that I felt best exemplified the central issues of each stage. The commentary included in the phases is a combination of supervisory comments coupled with further thoughts by the author in order to arrive at a more encompassing overview of the session in question. Two detailed clinical reports were selected for subsequent deeper analysis in phases 1 & 2 on a clear and defensible basis i.e. the sessions were chosen to demonstrate/reflect the theory for each particular phase. The author and supervisor considered these to be sufficient to make a sound analysis possible. With the vast volume of material available (some 125 detailed sessions in total) it was found impossible to analyse every line with equal rigour and not necessarily productive to do so. I discuss the development of my understanding from what was learned during the time when supervision was first given during the treatment of Kieron and that



discovered in my later analysis of the data in the last chapter entitled Findings.  
(See page 135)

From this research my hope would be that a clinician who is working with a child who has a predicted diagnosis of ADHD would be able to read this case study and decide for themselves how far and to what extent what is written is relevant to their individual patient. I would hope that having read this case study and being mindful of the observations and insights detailed herein it might allow room for thinking about their patient from a different perspective from that which they might have initially brought to their case. Child psychotherapy has made considerable use of successive case studies during its development as a systematic professional practice.

## Phase 1

### Case Background

This is an individual case study of a very disturbed, white, under five boy – Kieron - who was referred to the CAMHS clinic where I was working as a Trainee Child & Adolescent Psychotherapist. The CAMHS team were aware that I was looking for an intensive psychotherapy training case, and due to the level of his disturbance, the Principal Social Worker asked if Kieron might be considered as a suitable candidate. Kieron was then aged 3yrs 9mths. Psychiatric thought at this time was that although he was too young to be diagnosed as ADHD (i.e. under five); he was predicted to receive a diagnosis of ADHD by the time he reached five years. Kieron had severe sleep disturbance (unable to sleep for longer than two hours during the night) and both Kieron and his mother (Viviane) were suffering from extreme sleep deprivation and high energy levels, but these were only the preliminary factors being considered in a series of past misdemeanours that were contained within the GP's detailed referral letter;

*“Kieron regularly displayed destructive and violent behaviour towards his mother and siblings (including swearing, biting, and hitting out), Kieron refused to go to bed until around 11.30pm (and then not to sleep, but to watch TV alone), Kieron is frequently enuretic and encopretic (sometimes deliberately), Kieron killed his brother's pet hamster (throwing it up against a wall until it died), Kieron had drowned his brother's pet kitten in the toilet (afterwards he recovered it and placed it back in its basket), Kieron tried to catch the second kitten (his sister's) with the same intent but was prevented from repeating this action by mother, Kieron frequently rises before other family members and leaves the family home, Kieron had defecated in his sister's bed, and smeared faeces over the bathroom walls, although Kieron starts his bedtime in his own bed, he does not settle down to sleep there, he gets up several times nightly and goes to sleep with mum (often after wetting his own bed, and frequently wetting and defecating in mum's bed also)”.*

The family background was also disconcerting; there is little information about Kieron's father (Big Kieron) early history. What was made known to our service via Viviane concerned Big Kieron's mother's difficulties with his behaviour from a very young age. She had also sought professional help, and there were apparently regular police interventions that centred on Big Kieron's thefts and assaults as he was growing up, and also in adulthood. Big Kieron was convicted and imprisoned when Kieron was four months old for drug supplying offences, leaving Kieron's care (and that of his two half siblings Jake 9yrs and Bethany 7yrs) to Viviane who was also a drug user (principally marijuana). Big Kieron has a diagnosis of Anti-social Personality Disorder (APS), frontal lobe syndrome and ADHD, and has been imprisoned on numerous occasions for theft, and grievous bodily harm. Big Kieron also had another son (by a different mother) Kevin, who had also been diagnosed with ADHD. Kevin is also seen by the same CAMHS clinic Psychiatrist and is on prescribed medication – Ritalin.

Viviane's previous marriage with Peter had ended in divorce through domestic violence. Jake and Bethany had unfortunately witnessed many scenes of their father's attacks on Viviane. At the time of referral there had been no contact between Peter and his two children for five years. The children were very much encouraged by Viviane to think of Big Kieron as their father, and she was insistent on *"how important it was for the children to have a male role model"*.

During Big Kieron's most recent imprisonment Viviane had maintained regular contact with Big Kieron, ensuring that Kieron faithfully accompanied her on prison visits. Jake and Bethany had also visited, but far less frequently. Vivian's stated reason for this discrepancy was that she did not want to disrupt their education. Viviane was adamant that Big Kieron *"had not been dealing, he had only been helping a friend out"*. In actuality, Big Kieron and his friend were removed by the police from the family home – they were taken from the family kitchen, and Class A drugs were seized and impounded. Viviane maintained throughout her appointments with the Principal Social Worker, that she was very much in love with Big Kieron, saying that *"he was the love of her life, and that he was innocent of the charges made against him"*.

Viviane, as mentioned above, was initially seen by the Principal Social Worker, who asked me to join her meetings with a view to Kieron possibly being a suitable intensive psychotherapy case. During the meetings I attended where Viviane, Kieron and the Principal Social Worker were present, Kieron was referred to as 'the devil' or 'evil' in a regular - even casual manner - by Viviane, and from her reports this view was also replicated and shared elsewhere by both family and friends. Interestingly, Viviane reported no such concerns from Kieron's nursery; they described him as a charming, helpful little boy, who played independently, but always complied when asked to do things.

The main role of the parent is to contain powerful feelings put into them by their baby – through the mechanism of projective identification – so that the baby is helped to process them and in this way the baby develops a capacity to think (Bion, 1962). In this family Bion's model of parent-infant interaction appeared to have been reversed; Kieron was the receptacle of mother's powerful negative feelings (as well as from other family members), and seemingly on a regular basis.

My personal involvement with Kieron commenced in August. My supervisor had suggested that I do an extended psychotherapy (six sessions) assessment with him due to his sociopathic behaviour. She felt that Kieron needed to be rigorously assessed to decide whether he had the capacity to be free from the hostile, devilish projections that he had been subjected to.

### **Initial Meeting**

In this first phase I would like to present some detailed notes taken from my initial meeting with Kieron, Viviane, and the Principal Social Worker. I have chosen this meeting because it was a very powerful and enlightening first encounter for me personally, plus it demonstrates clearly what I believe to be the dynamics operating between Viviane and Kieron in this family. Kieron was unboundaried, wild, out of control, hyper vigilant, aggressive, and psychopathic in his behaviour throughout the session.

Before my initial meeting with the Principal Social Worker, Mum and Kieron, I found myself to be quite apprehensive - his infamy had preceded him - and he

had already become something of an enigma in my mind. I had early phantasies about whether he was a mystery to himself too, and considered whether I was picking up on his uncertainty about himself. However, I saw no evidence of his uncertainty whatsoever in our first meeting where he behaved in a rather overexcited, erratic, superficial, and at times psychopathic manner. What was clearly evident was that Mum had a distinct lack of boundaries in the room with regard to his behaviour, and she was filled to overflowing with a litany of Kieron's misdemeanours. As Kieron moved around the room climbing up on the chairs, climbing over the back of the chairs, trying to get onto the table in the centre of the room (centre stage), Mum continued with her tirade, seemingly oblivious of what was happening. I noticed that Mum made no attempt to tell Kieron to get down, or restrain his behaviour in any way; instead she continued her diatribe and spoke as if Kieron's behaviour and her dialogue was a perfectly regular, even normal occurrence. This I found to be rather shocking, and certainly unnerving.

Mum spoke freely of how there had been arguments between her and her stepmother who had refused to have Kieron in the house, and how this had now caused a rift between Mum and maternal grandfather. I was mortified that this conversation was being had in the room with Kieron "very present", there being no attempt at discretion, and I became quite uncomfortable and distressed. Bion's model of parent-infant interaction (Bion, 1962) states that it is one of the main roles of the parent to contain powerful feelings put into them by their baby, through the mechanism of projective identification, and then to give these feelings back to their baby in a more digestible form. By this process the baby is helped to process their unmanageable feelings and can then develop a capacity for thinking. Unfortunately for Kieron this process seemed to be reversed, with Kieron being the receptacle of Mum's powerful negative feelings. Reid, (Reid, 1997) speaks of situations where the infant has experienced excessive projective identification from the mother into the infant as producing a *consequent* deprivation:

*"...Thus the infant is simultaneously both massively projected into and deprived of opportunities for projective and introjective identification*

*leading to an adhesive personality structure, false self, poor self image and, at the extreme end of the spectrum, autism”.*

The subject of children being projected into by their parents has also been discussed elsewhere, Winnicott, in a chapter entitled *Mother's Madness Appearing in the Clinical Material as an Ego-alien Factor* (Winnicott, as cited in chapter 20 of Giovacchini, 1972), speaks of his young six year old patient as having *“learned to adopt the extreme defences of nothingness or invulnerability”* and his *“being possessed by madness”*. Winnicott states that the boy exhibited his mother's madness in the room, and that this was something other than himself. Fraiberg, et al (1975), in their paper *“Ghosts in the Nursery: A Psychoanalytic Approach to the Problems of Impaired Infant-Mother Relationships”*, speak of the unremembered past of the parents being visited on their children. They hypothesise that parents who have access to their own childhood pain use this knowledge as a:

*“Powerful deterrent against repetition in parenting, while repression and isolation of painful affect provide the psychological requirements for identification with the betrayers and the aggressors”* (Fraiberg, et al 1975)

In this way the parental past is inflicted upon the child. In Kieron's case, this hypothesis seems to be significant; Mum had discussed some of her own personal history with the Principal Social Worker. This was not revealed in one session, but over the course of the time that the Principal Social Worker met with her whilst Kieron was in therapy.

Viviane recalled how her mother had died quite suddenly from a heart attack when Viviane was just 9yrs old. Viviane had fond memories of her early life with her mother and spoke about the big impact her mother's death had had on her. Viviane's account gives the impression that prior to her mother's death, there were no problems within her family, but it is important to note that Viviane was unable to give much detail about her parents relationship, and even less about her relationship with her father. Viviane's father re-married quite soon (the following year) to a woman who also had one daughter, Lizzie (aged 12yrs). Viviane described the fracture in her relationship with her father, on top of the

loss of her mother. Viviane reported getting on reasonably well with her step sister but not forming a very good relationship with her stepmother. There were frequent arguments between the two of them, and Viviane spoke of occasions where she had run away from home in her teenage years. Viviane did stay within the family however, despite several very physical disputes (needing police involvement) until father and stepmother emigrated to Spain when Viviane was only 16yrs of age. Viviane spoke of feeling abandoned by her father and she gave a vague story about going off the rails. In her early twenties, following a violent relationship with Peter and the birth of Jake and Bethany, Viviane met Big Kieron. Both Viviane and Big Kieron were involved with drugs; using and supplying.

There are other gaps in Viviane's story, about whose significance one can only speculate. One of particular note that arose in subsequent meetings between Viviane and the Principal Social Worker was Viviane's disclosure of her half sister's (Lizzie) allegations that she had been sexually abused by Viviane's father. Viviane stated that this was complete nonsense. There certainly seemed to be ghosts from Viviane's past being inflicted upon Kieron.

<b>My Initial Meeting Session Notes 24.8.06</b>	<b>Commentary</b>
<p>Both the Principal Social Worker (MS) and I went to collect Mum and Kieron from reception. MS opened the door with her fob and Kieron made a grab for it from her waistband but was too late. MS said that maybe Kieron would be allowed to do it later. We all sat (room laid out with 5 chairs and a small round table at the centre).</p> <p>MS introduced me to Mum and Kieron. Kieron completely ignored me as if I were invisible. He had wandered around the room and appeared engrossed in his surroundings. He was asked to</p>	<p>Kieron lunging towards fob – can't wait to get through the doors? Wants to be in charge?</p> <p>Accepts 'later' as an option.</p> <p>Not curious about Davina in the slightest. Needs to be active, moving.</p> <p>Kieron does respond to 'come and sit down' but not for long.</p> <p>Visibly enjoys being discussed – his</p>

come and sit down. He did so and sat almost smiling with a sense of pride whilst mum described how he had run away from the house that morning - letting himself out whilst the rest of the family slept- he had managed to escape and she didn't really know how, "I don't have a clue". Kieron looked eerie as he sat listening, with visible glee, as Mum spoke. His eyes were cold, and watching his seeming triumph and mannerisms, he appeared to me to be more than a little disturbing.

He got up and wandered around the room but his attention seemed split between exploring and listening to what Mum was saying about him. He became interested in a large box of animals and specifically with the Giraffes – which Mum said were his favourites – He didn't stay long before he was over at MS's desk trying randomly to get hold of everything off the top (books, papers etc). He occasionally paused and glanced around at intervals. I became very uneasy with his attentiveness as Mum was describing Kieron as evil, and how everyone referred to him as either a devil or as evil. She spoke of how his brother hated him, and how his sister couldn't stand the sight of him.

He seemed hyper vigilant, as well as hyper active, his eyes wide, darting around the room and fixing on nothing in particular. He wore a mischievous smile and was quite handsome with his green eyes and fair hair. He looked short for his age, but seemed to carry himself with the gait of a much older child.

Although he was emptying the animal box, he did not 'play' with the toys; rather he lifted one out after the other only to drop them and replace them with the next. His attention still

sense of pride palpable as he knows can outwit Mum.

Kieron feels a little malevolent in the room – cold eyes, triumph, and smile. Knowing he's the boss/ in charge.

Occupied but not occupied, not listening but listening intently. Doesn't want to miss anything – like the giraffes - long necked with acute vision and hearing I thought, just like Kieron, craning his neck, ears and eyes to make sure he didn't miss anything important. Puffed up with importance, feels sneaky, capable of anything.

Hostile projections – devil child, evil boy. Impact of Mum's words on Kieron? Distorted image or real image? How much is Mum's negative forceful projection and how much has he lived up/grown into them? Is this the only attention he receives? This little boy is full of shit. Seen as someone disgusting, reviled by all his family – outcast and out of control.

Kieron on the lookout constantly – needs to cover all angles. Why? Appears much older – grown up too fast? Survival? Neglect?

There was a sense that Kieron really didn't know how to play – knew how to empty and make a mess. Nothing lasts, nothing really interesting or holds his interest. Has he ever really held



seemed to be split between the animals and the conversation which he was listening to between Mum and MS.

Mum said how he had previously climbed out of his downstairs bedroom window. Mum said she was anxious because they live close to the park and there are a lot of "strange people hanging around there". Mum said that Kieron had left the house with only his trousers on, in an almost boastful way. Kieron appeared to be occupied with the animals, but his eyes and incline of his head indicated that he was simultaneously listening. He looked at Mum and MS briefly, and then his gaze returned to the animals. He turned them over in his hands; his back was half turned towards Mum whilst she spoke.

Kieron moved around the room climbing up on the chairs, climbing over the back of the chairs, trying to get onto the table, whilst Mum continued with her litany. Mum made no attempt to tell Kieron to get down, or restrain his behaviour; instead she continued her tirade and spoke as if Kieron's behaviour and her dialogue was a perfectly regular, even normal occurrence.

Mum spoke freely of arguments between her and her stepmother who had refused to have Kieron in the house because of his behaviour, and how this had now caused a rift between Mum and maternal grandfather. There were further reports of Kieron being evil and of him being possessed. Even though there were parts of the conversation that I doubted Kieron fully

anyone's interest in a positive way for any length of time?

4yr old boy with an adult who cannot provide safe boundaries. Allowed (in the sense of not prevented, maybe) to escape. Sneaking out, leaving no trace – invisibility, and ability to go unnoticed. No sense of danger of outside world. Can keep more than one thing in mind. Not the first time that he has heard Mum's litany? Trying to find out who he might be? Can he trust that Mum really love him as she says? Kieron appears to be turning things over in his mind while she speaks. Mum's superficial interest in Kieron, links to Kieron's superficial interest in the animals. Does he see himself as an animal? Who does he need to be turned over to?

Assault on the room. No restraint. Accepted by Mum as quite usual. Sense that he just gets on with what he wants to do whilst she talks at home too maybe? I wondered what would happen if he stopped? His personality and behaviour totally dominated the room and conversation - is this a common factor elsewhere too? Idea around that Kieron did not know how to interact with others except in the way demonstrated. He appears to fall from his Mum's mind as a very little boy, and he only seems to exist as a nuisance.

Disliked and hated by family members. Splits in the family due to his behaviour. This is a powerful little boy, who has had powerful projections put into him. Feelings of sadness for Kieron and his stunted growth.

Davina uncomfortable and in touch with a sense of his humiliation and shame – even if Kieron was not. My wanting to protect Kieron.

understood, I was mortified that this conversation was being had in the room with Kieron very present, there being no attempt at discretion, and I became increasingly uncomfortable and distressed.

I started to actively distract Kieron from his listening, and tried to interact with him more directly. I spoke to him about the toys, gently asking him questions and not simply observing. At one point he grabbed a giraffe and hit me across the face without any provocation. I was stunned, but managed to say simply that I didn't want him to do that. He dropped the giraffe and went onto the next thing. He had moved on, something he seemed very good at doing.

He had found different coloured marker pens and was interested in writing on the white board, and made huge scribbles. Mum commented on how great it was, which sounded unrealistic and false. He then wanted tissue to wipe it off, lunging and grabbing at the tissue box. He was not satisfied with one tissue and wanted more.

Mum described how Kieron's bed wetting had gotten worse. Kieron apparently starts off in his own bed at night, wets that and then gets into

Davina trying to engage Kieron in normal conversation, showing my interest. Kieron hit me – I was stunned as it was unprovoked. Annoyance that he wasn't able to listen to Mum and MS, interacting with me and playing with toys simultaneously – too many things going on? He was being verbally projected into within the room and by hitting me with the giraffe he was subjecting me to a similar attack. Letting me feel what it's like to be attacked. It hurts its sudden and is shocking. He lashes out at me in an attempt to listen to MS and Mum's talk? Did Kieron sense that I was trying to distract him?

When Kieron was offered a different point of view – "I don't want you to do that" – Kieron moves off immediately. Doesn't like to feel like a small boy who has been chastised. Kieron cannot tolerate discomfort; it seems to become overwhelming for him. Discomfort appears to arouse primitive and quite anxious, scary feelings for him.

Grabbing for tissues (grabbing for fob) – deprived boy, wanting to use up all the facilities just in case he doesn't get an opportunity elsewhere again. Empty, greedy, and sad feelings are in the room.

Wetting beds and moving beds – leaking everywhere. He cannot cope, floods indiscriminately – is it purposeful or

Mum's bed and wets that too. Mum said that this was difficult for her in this weather – it had been raining for the past four days – but she also mentioned later that she did have a tumble dryer – which was confusing.

Mum went on to describe how hard things had been with Kieron especially when he had been emptying out the washing powder and large bottles of juice drinks onto the floor in one big mess. She said he had also gone through another pair of shoes by scraping the toes out on his bike as he rode along. MS made a point of speaking to Mum about whether she is able to tell Kieron off when he does things that are wrong.

Kieron suddenly climbed up onto one of the chairs and this time mum did respond - she threatened to take his bike away if he didn't get down, which he responded to.

Mum said that Dad was refused parole and would not be out until at least February the following year now; she spoke of how disappointed she felt, and she sounded sad. Kieron climbed up onto the table, MS said he would hurt himself if he didn't get down, but again, Mum made no attempt to get him off, adding that "he seems to think he's superman at the moment" grinning.

Whilst Mum is speaking, Kieron constantly moves all around the room - not settling at anything except fleetingly. Climbing up on the table and over chairs, into everything, every inch of the room filled and invaded by/with his

arbitrary? What is he peed off about? Wants to punish /make Mum uncomfortable. Mum's contradictory statement about things being difficult getting the clothes dry, but also mentioning her tumble dryer.

What is it that this Mum finds so difficult? Attending to her young child's needs? Being a potent parent? Saying 'no' effectively? Mum making more of the wetting problem for MS to really know what an awful, smelly boy Kieron is.

Does Kieron draw the focus deliberately as a challenge? I.e. go on then tell me to get down! Mum takes in MS's comment about telling Kieron off – but mum interprets this as needing to issue Kieron with a threat. No praise was offered to Kieron when he complied.

Kieron upstaging dad – centre of the room. Doesn't want Mum to be upset – distracting her? Is this usual behaviour for Kieron? Is his behaviour partly a response to Mum's inability to cope – by offering her a distraction from her own difficult issues and feelings?

Mum grinning at Kieron's climbing – even though it's unsafe. Mum being unaware of danger too? MS asking Kieron to get down now and be safe. Mum making a joke of his behaviour – thinks he's superman. Not helpful/thoughtful.

Kieron picking up on Mum's anxieties – he is unsettled too – constantly moving around. Fills the space – like an animal marking its territory.

presence.

He found the box of animals in the corner of the room. He picked up each toy and then discarded it by dropping it onto the floor. He picked out the rhino bear and the panda and said they were going to bed and placed them in the farm shed.

Kieron then looked for the family of giraffes, finding first the mummy giraffe, then the daddy, and then the baby. He seemed quite fascinated that they couldn't stand up alone. He tipped them upside down to examine their legs. He managed to get first the mummy giraffe and then the baby giraffe to stand – placed the baby giraffe cuddling up with the mummy giraffe.

He then got the rhino up from bed and made it jump on a small man – Kieron said he had killed him – didn't answer when asked why the rhino had killed the man. Him jumping on dad or dad jumping on him??

MS told Kieron not to go on the table when he approached it again and starts to climb up. MS reminded him that he had already been told about that, Kieron surprised me by stopping.

Mum commented that when she tells him not to do things at home, he says that his Dad said he can do it. It seemed that Mum was not really able to answer when MS asked how she responded to that. I remember thinking that Mum had no valid voice/answer even though Kieron

Puts animals to bed – him the animal being put to bed? – How does Mum speak to him/treat him when they are at home?

Kieron looking for a family – animals fall over – perhaps an unsupported family? Kieron unsupported in the family? No man of the house? Mum not able to take on paternal function of boundary setting/restriction. How can Mum be helped to stand up to Kieron effectively? Wants the family to be united – but then only the baby and mummy giraffe are together – oedipal anxiety – having to share Mum with a Dad he has only seen for odd hours in a prison setting. Scary, frightening proposition for Kieron.

Rhino – very ferocious animal – jumping on the man – killing him – killing off Dad, notion of a Dad needing to be gotten rid of? Or is Dad the threat and Kieron is frightened that he will be trampled on? His feelings being trampled on? How has Dad's return been discussed/ explored within the family?

Kieron has a leaky mind – cannot hold instructions in it – lack of containment in his awareness. There is a lack of consistent discipline. Kieron demonstrates an ability to stop when he comes up against a consistent, resilient object.

Identification with Dad – what sense does he make of Dad's ability to do anything? Dad in prison but able to influence Kieron's behaviour. Dad appears to be colluding/encouraging Kieron, and Mum is seemingly accepting of this.

was the child.

Kieron moved quickly towards the white board and started to scribble. This was a messy drawing, but interestingly he did manage to draw some containing circles around it. The drawing looked like water.

Mum said that she was not able to cope and said she felt like she was at the end of her tether. Whilst she continued to speak, Kieron drew dots and circles on the white board. He moved around to the back of the board, and was about to start drawing when MS said that he wouldn't be able to draw in the black board because he wouldn't be able to see what he'd drawn because he needed chalk to help it show up, which we didn't have in the clinic.

MS prompted Mum to comment on one positive thing about Kieron. The only thing that she mentioned was that Kieron could play football really well – but this was marred by her added comment of “especially when he brings it inside the house”. When prompted further by MS, Mum added that he can ride a bike without stabilisers – and then this too was marred by her comment “when we are all out together he goes off on his own bike ahead of us all, and I can't see him, which is a worry, and then he gets back to the house before anyone else, unless his brother and sister are able to stop him” – i.e. head him off.

Kieron asked to go to the toilet. I took him and waited outside the

Not planned/thought about drawing – a mess. His life messy, he is a messy dirty little boy. Needing water to cleanse? Kieron possibly attempting to contain the messiness?

How does Kieron make sense of his Mum (the adult) stating she cannot cope with him? Feeds his omnipotent feelings?

Kieron's marks not fluid – listening at the same time? Who is the dot, who is the circle?

Kieron is able to listen to MS's logic and to another adult explaining why he was not able to do something – hopeful? Kieron does not experience this same thinking and discussion with Mum though.

Mum praising Kieron, but it felt false in the room even though it was positive. She seemed to be exaggerating his ability. Football in the house - lack of boundaries at home. Any positive comments by mum are negated by Mum's next comments. Mum unable to hold anything positive about Kieron in her mind for long at all.

Kieron desperate to get away – why? What from? Able to ride a bike – good co-ordination. Mum unable to give strict instructions that are followed by Kieron – there is vagueness and a feeling of inevitability around him being able to do whatever he wants to do. Kieron relies on other siblings to stop him – Kieron's view of mum, sees her as someone to ignore, ineffectual, unboundaried. Mum mistaking firmness (parental function) as being punitive – she is not able to give boundaries in a clear effective way (this needs exploration with mum).

Kieron leaving the room for the toilet –

door. Kieron told me not to come in when he came out and I asked him whether he had flushed the toilet. I was not sure whether he actually went to the toilet or not – when he returned to the room he smelled of urine when he returned to the room, but this may have been from his hands - he didn't wash them in the toilet before leaving.

Back in the room he took out the toy camera, and took a photo of me, telling me to "say cheese". Then told me to "say smile". I asked if I could take one of him and he said no, but then immediately afterwards gave me the camera. He said "smile", but didn't smile – strange as it didn't match!

Kieron was able to say thank you when I got him a tissue for cleaning the white boards. He did a good job of cleaning up the board.

Kieron hid an animal in the shed of the farm – "it's his home" he said. I said that I thought that Kieron wanted to be remembered when he wasn't here and that perhaps the animal liked being in there? And Kieron agreed.

Kieron remembered about being told he might be able to use the fob to get out of the door when leaving without prompting. MS gave him the fob to open the doors, which he did, and we all said goodbye.

uncomfortable with mum discussing him and his behaviour in front of me & MS? My feelings of being told off and put in place by Kieron when told not to come in – in my countertransference I felt like I was doing something perverse by accompanying him to the toilet. What has his experience been in the past? Bringing the urine smell into the room – quite literally peed off. Bringing his nasty smells physically into the room. Kieron not familiar with toilet behaviour – flushing the toilet, washing of hands etc.

Taking my photo – wanting to have a memory of me? Snapshot of someone different? Ambivalent about being seen (his photo). Said smile but no smile – odd. Face reflection of real internal state – not modified by social interaction. Sad lonely dirty smelly boy.

Can say thank you – familiar with cleaning up – perhaps familiar with cleaning up at home? What activities does his mum show him how to do? General cleaning but not cleaning himself. Wanting to wipe things out completely – new start? Possibly a good indication for therapy?

Kieron feeling at home – likes being at the clinic and wants to be remembered. Able to keep in mind the key fob – possibly another good indication for therapy? Able to ask for what he wants

Able to hang on to what is promised and defer gratification.

## Discussion

Kieron was very active in the room and seemed extremely restless: occupied but not occupied, not listening but listening intently. Kieron filled the space, like an animal marking its territory. I considered whether Kieron was picking up on Mum's anxieties as she described his uncontrollable behaviour, and whether there was some excitement being aroused in him by mum's negative tirade. He demonstrated aggression as well as an inability to focus, play, or interact in a meaningful way for any length of time. It seemed that he didn't want to miss anything – rather like the giraffes that have long necks and acute vision and hearing - craning his neck, ears and eyes to make sure he didn't miss anything that might be important for him not to miss.

At certain points he seemed to be visibly enjoying being discussed, with a sense of delight and almost pride that he could outwit his Mum – the adult. Kieron was “puffed up” with importance. Through my listening to Mum, Kieron felt sneaky, and quite capable of anything. There was a definite feeling of malevolence about him; his cold eyes, triumph, and smile, were all indicators that he knew he was in charge of Mum and he revelled in it.

When he left the room my mind felt assaulted, and in a complete muddle. I was exhausted and reeled from the impact of both Mum and Kieron's behaviour in the room. I remember thinking “what was that?” as they left. The suddenness of his physical attack on me had left me stunned. Mum's diatribe of projections which were being directed towards him in the room seemed to be too much for Kieron, and by hitting me with the giraffe he was subjecting me to a similar attack. He was letting me feel physically what it's like to be attacked i.e. It hurts, it's sudden and it's shocking.

There is a great deal of literature by authors on anti-social acting out in the psychiatric domain, but few in the psychoanalytic. One article that seems particularly relevant when considering Kieron's case is *The Genesis of Antisocial Acting Out in Children and Adults*, by Johnson & Szurek (1952), which focuses on the parents vicarious gratification of their own poorly integrated forbidden impulses in the acting out of the child, through their

unconscious permissiveness or inconsistency toward the child in these spheres of behaviour.

*“Firmness bespeaks a parent who has learned how to gratify all his essential egocentric impulses non-destructively to himself and to others’ such firmness may be devoid of masochistic or sadistic colouring and distortion”* Johnson & Szurek (1952)

Where ‘love’ is given by a parent to their child and it includes *rationalisation* of guilt about their own sadomasochistic impulses, and these are conveyed to the child through what might be experienced as ‘gentleness’ or ‘indulgence’ by adults, the child may experience their parent as condoning, or even accepting of their behaviour. I think that Kieron’s mother was unable to adopt a firm parental stance with him, and her sadomasochistic urges were projected into Kieron. Johnson & Szurek (1952) offer that the parents needs exist because of some current inability to satisfy them in the world of adults, or because of the stunting experiences in the parent’s own childhood – or more commonly, because of a combination of both of these factors. In this family, it seems as if Mum’s sadomasochistic needs may have previously been unconsciously met through Big Kieron’s behaviour before he went into prison, and once he was imprisoned, her drive to have her needs fulfilled pressed her to find another willing vessel; namely Kieron. As Mum’s needs are unintegrated, unconscious and unacceptable to herself, Kieron will almost inevitably act out these projections unconsciously too, leaving Mum free to continue to project and not personally own any of her needs consciously.

Big Kieron, as mentioned previously, has a diagnosis of Anti - Social Personality Disorder (ASPD). Longitudinal studies have consistently shown that adult anti-social behaviour and psychopathy have important roots in childhood. To my knowledge there have been no studies that examine parental childhood experiences and the experiences of their children for similarities, and acted out projections, although this would be an interesting area for further exploration.

Mum’s inability to think about or process her own sadomasochistic tendencies, albeit unconsciously, needs to be examined. Mum grinned in the session when Kieron was climbing – even though it was clearly unsafe. Her body language



would give Kieron 'the green light' to continue, I considered whether Mum was also unaware of the danger, and that being the case, how safe was Kieron in Mum's custody? Mum's response to the Principal Social Worker asking Kieron to "get down now and be safe" was for Mum to comment, in a joking manner, about Kieron's behaviour "*he thinks he's Superman*" which was not helpful or thoughtful in regulating Kieron's dangerous behaviour.

In this initial meeting Mum spoke with real conviction of Kieron's uncontrollable behaviour, but what was noticeably absent from the room were any feelings of hostility or hatred that she may have felt towards him directly. It is quite probable that her own destructive feelings towards Kieron created immense feelings of guilt in her own internal world, which would have added to her inability to be firm and fair when his behaviour warranted it. What she brought to the session were her tales of woe, "poor me", and "I've tried everything", leaving her very much in the role of martyr to the cause – which in her mind had become a lost cause. Unwittingly, Kieron had somehow become identified with his parents' unconscious as well as their unconscious concept of himself. I say 'parents', as it is, I feel, also very interesting to note that Kieron's father was imprisoned, and Kieron was displaying behaviour whereby he was escaping and running off. Whether this was Mum's unconscious phantasy of Kieron being a 'chip off the old block' and managing to escape as a means of wish fulfilment, or whether this was Dad's phantasy along similar lines or a combined phantasy of both parents is unclear. Also, despite Big Kieron being imprisoned Mum reported that he still had a strong influence on Kieron's behaviour, and Mum seemed to be amazingly accepting of Big Kieron's influence and welcomed it. There is a real sense that Mum is in an almost delusional state in relation to both Big Kieron and Little Kieron's behaviours – blind to the seriousness of the situation and the developing situation respectively.

What was remarkable to witness was that although Kieron made an assault of the room whilst with the Principal Social Worker and myself, he was unrestrained and not reprimanded; Mum appeared to be silently complicit. There was a strong sense that his behaviour at home was perhaps identical to that which he displayed in the room, i.e. normal for Kieron. Also I wondered if Kieron was left unsupervised, and allowed to get on with whatever he wanted to

do, perhaps while Mum spoke to her friends about Kieron's behaviour. Kieron demonstrated little insight into how to interact in a meaningful way. It seemed as if Mum only had room in her mind for Kieron as a nuisance, and not as a sad, angry, lonely little boy in need of her help and support.

Kieron appeared to be so much older than his years, and I considered just how much he may have had to bring himself up without any clear guidelines of how to achieve this. He appeared to have little knowledge of usual toilet behaviour i.e. flushing the toilet, washing his hands etc; perhaps he hadn't ever been shown? The whole room and focus of the session was Kieron, and when the conversation did focus elsewhere i.e. Big Kieron, Kieron began to upstage dad in the centre of the room. Kieron seemed almost to be distracting Mum from her disappointment about her husband's delayed release from prison. I considered whether this was usual behaviour for Kieron, and even that his overly active behaviour "jollied" Mum along leaving little time for disappointment and sadness. Kieron brought the smell of urine into the room, and he said "smile" when using the camera, but no smile was reflected on his face – which seemed rather odd. I considered whether his expressionless face was a reflection of real experienced internal state, and that it had not been modified by social interaction. He was in truth a sad, lonely, angry, dirty, smelly boy.

## Assessment Sessions

In discussions with my supervisor it was very apparent that Kieron would need considerable containment in the room, in order to help him feel safe. His risk taking behaviour was uncontrolled and not regulated in any observable way. Jan Anderson's study (Anderson 2001), explored risk taking behaviours in children and examined their home life through the lens of identifiable 'havens' that the child may experience; illusory, no haven, or perilous, all three havens identified are dangerous for children. Anderson offers a different prognosis and strategy for each haven identified. Kieron seems to fit into the perilous haven category where the mother is pre-occupied with her own thoughts and speaks to the child in a different voice from the one usually used when speaking to another adult i.e. mother is artificially bright and cheery. Anderson speculates that this may occur through mother's own efforts to overcome her own feelings of depression and may represent an attempt to be lively for her child. She states further that this "out of touchness" of mother creates a gap in the mother-child relationship which, as it is not supervised, creates a space that is filled by the child through dangerous activity. The suggestion is that the child is unable to manage the distance and lack of supervisory care and acts into the space that is created in a dangerous way. This may be to attract some sort of attention, but may also feed the child's omnipotent phantasies of invincibility.

Kieron's constant moving around the room, his continuous changing of focus might also be seen as an attempt to avoid the gaps that he experiences internally. The movement could almost be described as a pacifier for internal anxiety that Kieron feels unable to bear. Winnicott stated that:

*"The child that cannot think is at the mercy of "unthinkable anxiety"*  
(Winnicott, 1962)

Kieron's internal support or coping mechanism has developed in a distorted way with a fear of falling apart quite possibly being the unconscious motive. This I believe would be in response to Mum's unconscious communication of distance. In this way movement is an unconscious life choosing option when faced with feelings of nameless dread and annihilation (Bion, 1967). Perelberg,

writes that when an individual is in a heightened state of anxiety the boundaries between body and mind become blurred, so that:

*“There is a tendency for body and mind to become confused, so that violent acts on one’s own or another’s body are used to get rid of intolerable states of mind”.* (Perelberg, 1999)

I saw Kieron for two more sessions that were planned to coincide with Viviane’s meetings with the Principal Social Worker on a fortnightly basis and continue his assessment. These sessions started with us in a room together, and after ten minutes or so I would take Kieron to a different therapy room. On each of these occasions Kieron was eager to leave and go to the therapy room with me. This room contained a box of toys, a small table and two small chairs, a sink at child height with running water, two larger chairs and two storage cupboards. Kieron appeared to be in a hurry to get to the room and often played in the cupboards and told me where to find him. I got a strong sense that he took pleasure in the sessions, he emptied toys into the sink, he threw toys around the room, he climbed up on tables, chairs and the cupboards, and he kicked a ball around the room indiscriminately. The sessions were filled with activity and lots of Kieron’s aggressive, inattentive impulses. It often felt after sessions that he had made use of absolutely everything in the room, and sometimes all at once! I left sessions totally disorientated and exhausted, wondering what I had just encountered and in a blur.

It was felt by my supervisor that Kieron needed to be rigorously assessed due to his exposure to the poisonous comments of his family. He seemed sociopathic in his behaviour and careful consideration was required to decide whether he had the capacity to be free from their hostile devilish projections. I met with Viviane to offer a few extra sessions to Kieron where we would meet alone as a means of assessing whether he would be able to tolerate a full fifty minute session, and his suitability for intensive three times weekly individual psychotherapy. There was gap in our meeting due to my annual leave and a half term break. Looking at the material now, it is quite evident that I had little to no idea about how to manage this excessively lively small boy in the room. I started seeing Kieron when I was in my second year of training, and up until

that point I had had no experience of dealing with such an aggressive, psychopathic, and whirlwind character. I do remember feeling stunned at the end of his early sessions as well as de-skilled and almost useless in safeguarding him. I used to feel that I had done well to survive fifty minutes alone with him in a confined space, and pondered what it would be like to live with him for 24hrs a day.

In these early stages, my supervisor had a great deal of supervising to do, and gave me techniques to try to help slow him down and feel more contained in the room. My supervisor had had many years of experience of working psychotherapeutically with children, including children with ADHD. I in comparison had had very little. Indeed, Kieron's early containment and safety became the major focus in our work together. The sense that he was invincible was unquestionable in his mind; his actions were clear evidence e.g. climbing up onto cupboards, climbing over the back of chairs, wanting to stand on the top of a chair back, climbing and jumping off from the sink, and reprimanding me when I said he needed to get down as it was unsafe, with comments of *"I won't fall"*. It felt as if the idea of safety had never been introduced to him, and he often looked at me as if I were crazy to suggest that something he believed he was more than capable enough to do might actually be quite dangerous indeed. Corners of cupboards, three legged table, closing mechanisms on doors, shelf supports in the cupboard which previously I had just thought of as furniture in the room, suddenly became potentially dangerous if fell upon, stood upon, closed without thought, leaned into – all of which Kieron tried out, whilst exploring the room. Safety and thinking about safety in the room seemed a whole new idea to him and a whole new world of potential danger for me in my countertransference. Whilst I was concerned for his safety, he had no need to be, all the anxiety was mine, and in the early days mine alone.

Kieron was able to remember things from previous sessions, and appeared to enjoy the one to one attention in a setting where he did not feel berated with venomous projections. Although Kieron clearly had a mind that was leaky - in the sense that he could not hold onto instructions (through lack of containment and lack of consistent discipline), he also managed to demonstrate an ability to stop when he came up against a consistent, resilient object. Even in the initial

meeting session with the Principal Social Worker, Kieron had demonstrated that he was able to listen to logic and reason from another adult; his acceptance of explanation when linked to why he was not able to do something was seen as a sign of hope by both me and my supervisor. The importance of why certain behaviours were safe and others dangerous became an important part of our later work together, when it seemed that these ideas were being introduced for the first time.

Other indicators that he might have found therapy useful was that he felt comfortable and 'at home' when playing with the farm animals, he seemed to be looking for a family in the sense that he gathered families of animals together, and he wanted a photo taken of himself. This possibly was an indication that he wanted to be remembered, wanted his face to be seen and wanted to come back again. He also showed that he could hang onto the idea of having the fob at the end of the session without constantly referring to it, and this too may be a possible indication that he could keep some things in mind, and was able (at least with regard to the key fob) to defer his pleasure. He was also able to ask for help when appropriate and necessary. From his extended assessment it seemed clear that Kieron was engaging in the therapeutic relationship and would benefit from more intensive work. With all these things in mind and after a thorough discussion with my supervisor, it was decided to offer him three times weekly psychotherapy.

I met Viviane together with the Principal Social Worker and discussed that this would involve Kieron's attendance regularly and that this was paramount to taking up the therapy. Viviane readily agreed to bring Kieron and assured us of her commitment to the therapy and to bringing him for the sessions. It was also agreed that Viviane was to meet once weekly with the Principal Social Worker, alongside one of Kieron's sessions, to help her think about her relationship with Kieron and what she brought to it. It is important to note that despite strong unconscious impulses that could be seen as quite detrimental to Kieron's emotional psychological health, there was another more healthy part of Mum that really wanted him to be well, and be different from his father. This Mum came from a working class background, and a working class subculture. Looking back, although Mum may have not fully understood what bringing

Kieron to therapy three times per week would be like in actuality, she did manage to bring him. This is a monumental achievement for any parent, let alone a parent from such a deprived background. I think this adds testimony both of her conscious love for her son, and also her own unconscious needs that required her own therapeutic input.

During these individual sessions what stood out most was Kieron's constant use of the cupboards. At the time, I thought of his preoccupation with hiding and being found in terms of his coming and going to and from the clinic – a sort of 'now you see me now you don't' enactment. I have found it very interesting whilst conducting this analysis – after our individual work had ceased – to discover a whole new layer of meaning to Kieron's use of the cupboard as a container for himself. Not merely as a container of his feelings, but a protective space that he felt physically safe and secure in. He didn't want to hide and not be found, he wanted to hide, and tell me where to find him, almost like on an unconscious level he knew that I was there to help him find an external space that he could internalise and make his own that was free from his thoughts of falling apart and being forgotten or overlooked. He consistently started off the session in the cupboard, and then came out into the room to look at other things. He retreated to the cupboard when he had been asked to do something that he didn't want to do – like it was a safe haven, where he could withdraw to and be in control. Writing this now, there is a feeling of coming and going, experimentation even on his part, a learning experience that it seemed that he was keen to engage in and dare I say it, get right. Certainly, there was a strong sense of a containing cupboard that helped Kieron to adapt and emerge into the therapeutic space of his sessions. I believe Kieron experienced the therapeutic space as somewhere he was free to be himself, and not merely the object of another's projections.

## Phase 2

In this Second Phase, I will be looking in depth at two individual sessions with Kieron. The first session that I would like to examine and comment upon was my first full therapy session together with Kieron. This took place some eleven weeks after the initial session mentioned previously in Phase 1. Mum had been true to her word and brought Kieron regularly for his appointments, and he had already begun to feel a little bit more contained in the room. In Phase 1 it was impossible for me to keep Kieron safe and dry in the room. He would crash into things through his boisterous behaviour and somehow manage to get himself and his clothes wet, despite my attempts at warning him of potential hazards. In this phase, he no longer left the session completely wet from playing at the sink with the water, and he wasn't leaving with injuries that he had incurred in the sessions – which he had done initially on a regular basis. This made me feel a little less de-skilled and helpless in my countertransference. At our first meeting I could see and feel how repellent he could be as well as also being able to respond to the needy, deprived little boy inside of him. During the course of Kieron's therapy in this phase, as I gained in confidence and realisation that he could – and I might say wanted to - be managed, there was a marked change in Kieron as he began to respond very positively to my attentiveness and my being in touch with him.

My supervision was focussed mainly on setting clear boundaries and being consistent in my instructions within my sessions with Kieron. It felt a little unlike any form of therapy I had encountered thus far, but it seemed to have the desired effect in the sense that Kieron interacted well and seemed more contained and able to settle in the room:

Process 14.11.06	Session	Notes (1)	Commentary
		Kieron and Mum arrived on time. When I walked along to reception mum was watching my approach through the glass. Kieron was looking at a comic and didn't see me open the door as he had his back to me. I said "hello Kieron",	Kieron comes to session easily enough, although anxious – used to containing his own anxiety?  "No I'll sit here for a bit longer" Mum not being strictly truthful which places me in a technical dilemma. If Davina tells the



and Mum said "Davina is here". Kieron turned around and smiled at me, got up quickly and walked towards the door. He turned and said "come on" to mum, who said "no I'll sit here for a bit longer". Kieron said "come on", and Mum shook her head and said "I'll wait here". Kieron shrugged his little shoulders and came through the doors. I said "Mum will wait for you in reception", and Kieron said "I can go by myself I am a big boy now". As we passed down the corridor I asked Kieron if he remembered which room we were going to, and he made a step towards the psychiatrist's door, and I said "not that room today, our room is over here isn't it".

Kieron went into the room and went immediately over to the bin. It has a flip top lid. He put his foot on the pedal and laughed as the lid popped up – doing this repeatedly. "You pretend there is rubbish on the floor and put it in the bin" he said. I picked up imaginary rubbish and walked toward the bin. He opened the lid and I pretended to throw it in. "There's some more" he said, and this was repeated. I asked him "what sort of rubbish am I putting in the bin today" and he said "all sorts". He looked around the room eagerly and saw his box which was on the table. He went over to it. "What's in here?" he said, trying to get the lid off. I said "when you come to meet Davina this box will be here and it was for

truth or challenges what Mum has said then Davina will put herself in opposition to mum. – Mum not being clear – not explaining why he is there – confusion. Why isn't she truthful? What are the implications for Kieron? What is hidden in this family? What cannot be spoken about?

"I can go by myself I am a big boy now". Kieron doesn't know who he is and has a pseudo adult self of at least 6 or 7. Doesn't know how to be a little 4yr old boy. His use of language demonstrates his anxiety and it is used to help him feel better about going off with someone he is not close to alone. Holding himself together – pseudo maturity – prevention from falling apart – learned response to difficult situations – reliance on self – "bigged up" self – inability to be small/helpless – would be too scary / overwhelming. Psychiatrist's door – remembers previous visit to psychiatrist, but not the room we met in for our assessment sessions (many more visits but forgotten). Cannot remember exactly which room, but is eager and curious.

Flip top lid on bin – "all sorts" – all sorts of rubbish. What is good and what is bad (rubbish) – is this a good place or a bad place? How will the therapy deal with Kieron's rubbish? Can it be gotten rid of (in the right way, in the bin) Can the therapy help with the rubbish inside him – or said to be inside him (projections of others). Frightening internal picture of himself – someone evil/bad. Goes immediately to the bin and presses the pedal of the bin repeatedly. Wants to put thing in the bin – wants to get rid of something. "You pretend there is rubbish on the floor and put it in the bin he said" Bossing Davina around

Kieron looking through the box – Look he said, there's a teddy, and a bike. Kieron takes out things and puts them on the

him to use in the room, and that nobody else would be using the box". "Look" he said, "there's a teddy, and a bike". He took out the teddy and put it on the table and then quickly moved onto the next thing. He put the bike on the table and said "this is a really good bike isn't it". I said that he really liked the bike and he said "is there another bike?" I said that maybe he should have a look inside the box. Kieron found another bike and said "this is a police bike isn't it?" And I said "it looks like a police bike". Kieron then got out the cars and commented on each one, saying "this is a racing car, and this is a big car, and look at this red racing car". The table looked as if it was getting a bit filled up and Kieron said, "I'm going to tip this out" and he lifted the box down to the floor and emptied it out. He said what he saw, pens, animals, then... "What's this?" he said (holding up the glue and twisting the end). I said it was glue and that there was a lid on the end. "This is great" he said, "but I need some paper now", and I said there was paper in his folder.

table and then quickly moves onto the next toy rapidly, naming objects, excited. Seems pleased with the contents (likes bikes – something mum had told me previously – that had been bought with him specifically in mind).

Police bike – the authority figure – punitive superego – will it look after him, set limits or punish him – note dad in prison

Naming of the cars – colours – something familiar to him developmentally – sense of security? Kieron then got out the cars and commented on each one, saying this is a racing car, and this is a big car, and look at this red racing car going through a list, but bores quickly as the table fills up and he needs to see what else is in the box Plays with the contents but fleetingly.

*"What's this?"... "This is great"* he said, *"but I need some paper now"*. His reaction to the glue and paper seems as though he sees them as being given presents. Need to try to slow him down – things moving too fast. Excitement with contents – tipping out the box to get a better look at contents – wanting to get right inside Melanie Klein's scooping out of the breast - asking questions *"what's this?"* can some things be put together, and will this be secure or make a mess? Can I help him stick things together – internal fragments? Wanting more (greed – Melanie Klein – deprivation?)– enthusiasm for the toys etc but the difficulty in staying with anything in particular – an appetite to learn and play but a difficulty in keeping calm enough to do so – he is easily over stimulated, like someone being offered food when they are desperately hungry. His enthusiasm/greed could be taken as evidence that he has a lot of life and

He took out one green and one yellow piece. He picked out a blue pencil and drew on the paper. He got hold of the glue and started to put glue on the blue drawing.

He then gave it to me and said "this is for you". I said "thank you", but he had already gone to get another piece of paper to draw on. He then said he was going to cut the paper, he tried to cut the paper but it flopped in the middle, so he only managed two cuts, but while he was cutting he said "this is fantastic" he said "isn't it?" I said that he really liked cutting the paper – he finished abruptly throwing the paper and the scissors to one side on the floor when he wasn't able to cut the paper properly. He went over to the armchair and climbed on it and then did a big jump off of it.

He went over to the cupboards and opened and closed the doors and said "we can hide in here, I will go in this side and you can look for me in that cupboard there" (pointing at the next door cupboard, whilst climbing into the cupboard closing the doors behind him. He added "you don't have to count this time". (This is a hide-and- seek game that we played in our assessment sessions together that he had remembered).

I said, "I wonder where Kieron is today, is he in here?" Opening the cupboard nearest to me, and then

potential which his parents have not only not been able to contain but also not able to nurture and develop.

He took out one green and one yellow piece.... *"This is fantastic he said isn't it?"* This seemed all very manic. Scribbles briefly on the paper then wants to give me a present, but feels very superficial, like the comments of *"this is fantastic"* – strong traces of Mum

Giving Davina a picture as a present (was this in return for his box?) possible demonstration of gratitude?

*"This is fantastic isn't it?"* Inflated sense of what he can achieve – internalised untruth (see above) from mum. "Bigging him up" as a way of holding together his fragile ego (self esteem/confidence). Co-ordination not developed enough – discards paper and scissors when reality of situation hits him. Moves away from the discomfort...*he finished abruptly* Added interpretation here "I said you liked it but you got frustrated when you couldn't do it how you wanted to do it". He went over to the armchair and climbed on it and did a jump – dangerous behaviour. Moving around the room unable to remain focussed.

He went over to the cupboards and said we can hide in here. *"I will go in this side and you can look for me in that cupboard there"* gets bossy again – follows from disappointment of not being able to cut properly. Hiding in the cupboard – hiding from discomfort of his own smallness? Not just when he comes and when he doesn't – which Kieron am I going to find inside? – Can I help Kieron find who he really is on the inside and can I tolerate it (the evil, messy, murderous Kieron).

Wanting to be found/helped by indicating which cupboard to find him in, but wanting Davina to look in the wrong cupboard first – is he worth looking for? Will I keep

said aloud, "no he's not in here; I wonder if he's in here?" Opening the second cupboard. Kieron grinned up at me and came out. I said that "maybe this game is about the times when Kieron comes to see me and then he doesn't see me for a while, but now he will be able to see me three times per week." Kieron smiled and went over to the armchair and did a big jump again, and I said "Kieron is showing me again that he could do big jumps and he felt all grown up".

Kieron went over to the table and picked up the motorbikes again and moved them around the table making car noises. He said that the small one was the granny bike and that the big bike was the daddy bike. He said that I could have the granny bike, and he would have the bigger one. I said that he wanted to be the daddy and he said yes. He positioned his bike opposite to mine and said "hello, how are you today", I said I was fine and I asked how he was today and he said "good". He drove his bike across the table away from the granny bike and then said "come on". I said "I wonder where we were going" and he said "shopping, for apples and bananas and stuff". I said we were food shopping together. I said I would follow him. He led the way and I followed his bike with mine. We did this for a few minutes.

Then Kieron looked around the room and I said he seemed to be looking for something. He went over to his things on the floor and picked up the ball. "I know what

looking if I don't find him straight away? Is he worth the effort or will I get fed up like other people in his life?

I said he was showing me again that he could do big jumps and he felt all grown up". Jumping around after a short burst of familiar play. Note, need to keep an eye of his jumping around – not too much

"...and picked up the motorbikes again and moved them around the table making car noises" Kieron's play is back again to the bikes with short burst of conversation.

He cannot bear to be small, Davina has to be the smaller/granny bike and feel smaller and more vulnerable.

*"Hello, how are you today"*, sounds like a tv programme he has watched with a nice world, "and off we go!" feel. This world switches/ is dropped to be replaced by something more hostile. Potential violence of his games – what is he to do with his aggression, and how to stop it leading to hurt for him or his objects/family?

*"Kieron looked around the room"* he is back to looking around for some new stimuli.

*"I know what this is"* this boy is full of hostile/devilish projections

*"We had to be a bit careful in the room so that neither one of us got hurt."* My comment here may work but possibly I am

this is" and he held it up and let it drop and caught it again. "I can kick this I can" and he did. I said we had to be a bit careful in the room so that neither one of us got hurt by the ball.

He tried to kick it again, but this time he missed. He tried again and missed again. "Oh dear" I said, "you missed it".

He came towards me and saw my name tag and door entry fob. "What's that" he said, then "come over to the door and pretend to open it". We walked over to the door and he took the fob and put it to the door knob, he tried the door but it was locked. Kieron said that he wanted to see his mum. I said that we still had time left before we went to see mum. He said that he wanted to go now, and I said that we had to stay in the room for a bit longer. He pulled at the door and tried to unlock it, and I said "no, we won't be going to see mum just yet, but she will be waiting for you when we finish". Kieron started to moan, and I tried to distract him by saying "you see that clock up there, well; when the big hand gets to the four we will go and find mum".

There were no real tears, although he continued to moan and ask to go. I stayed firmly by the door and he suddenly went over to the sink and turned on the taps. He reached into the sink and put in the plug. I said I wondered if he remembered how much water he

giving him a mixed message, note - see how it goes.

*"... tried to kick it again, but this time he missed..."* trying to find something he can do after he has said he can kick it but unfortunately misses. *"Oh dear I said, you missed it."* Kieron has no real strong ego, he might hear what I say in the wrong way, and it's very different from mum's hyper comments that are all praise with little depth of feeling. ? Did my saying he had missed the ball make him remember his mother and how he might miss her?

Unable to tolerate the disappointment or stay with it. Instead he's off looking at the entry fob (which reminds him of his mum in reception. He came towards me and saw my name tag and door entry fob. Entrance to the corridor that leads to the therapy rooms is via electronic access by fob. My fob is attached to my name badge. Kieron remembers that to get out and see his mother he would need the fob – he tries it on the internal door – which is locked only by a simple catch. Pushing boundary of when to leave/finish session.

Moans but no real tears – demonstration of his will, and how he gets what he wants? Moves away from discomfort – over to new activity – the sink

*"Suddenly went over to the sink and turned on the taps"*. Realises that his moans have not worked and suddenly changes his mind about being upset! Almost like a switch was flipped.

*"...watch the water level, but he wasn't listening. This is good my dear he said"*. Kieron engrossed and oblivious to my speech.

could put in the sink, and Kieron said "lots". I said "yes you can put lots in, but that the water wasn't to go above the level of the bottom of the black waste" – pointing at it as I spoke. Kieron pulled at his sweatshirt and was struggling. "Can you do it for me" he said, I said that "Kieron needed help as it was getting stuck on his head". Once off Kieron said, "I'm going to put the animals in the sink", I said "this was something Kieron had done when we met before. What were they going to do in there?" I asked. "They are going to have a bath" he said. He picked out the giraffes and first put the small giraffe in and said it was underwater. He started to pull at his t-shirt and said it was wet. He managed to get this off himself, which I commented on. He put in the big giraffe and then turned on the taps again. I said "don't forget to watch the water level", but he wasn't listening. "This is a good my dear" he said. I repeated what he'd said and he said it again. I watched and thought he was going to see how much water he needed in the sink before the big giraffe was under water too: Which is exactly what happened.

The big giraffe fell over and he said "it's drowned". I said "I wonder why it had drowned" and Kieron didn't reply.

*"This is good my dear"* – sounded odd – something heard on a tv program? Sounded too mature /old fashioned from him.

Watching to see when the giraffe was under water before he switched off taps. Had he heard my comments about the water level? Drowning of the animals and the difficulty of keeping everyone safe. Outpouring of destructiveness in the urinary flooding model (Klein in relation to babies) Clear boundary about the level of water given – trying to engage Kieron in remembering/linking what he is doing in this session with previous assessment sessions. Kieron remembered that he had gotten wet previously – trying to remove sweatshirt – asking for help when stuck. Managing to take off t-shirt himself. Putting animals in the sink- previous play. Ignoring my watchful words – engrossed? Deliberate?

Instead he went over to the toys and picked out the dad doll, and put him in the sink Kieron wanting to play not talk, cut off from any interaction. *"... went back to the toys and took out the tea pot. And started to fill it moving around the room"* - filling the space

*"She's drowned"* he said. Note – try not to question what he did, he won't know,

Instead he went over to the toys and picked out the dad doll, and put him in the sink and it fell over. I said that “now dad had drowned”, “yes” he said then went over and got the female girl doll and put her in too. “

She’s drowned” he said. Then he went and got the mum doll and put her in too. “Are they all drowned?” I asked. Kieron said simply, “yes”. He then went back to the toys and took out the tea pot. And started to fill it in the sink water and walked it over to the bin and poured it in.

He went backwards and forward filling it each time and I commented on what he was doing. He started to miss the bin and I said that “some of the water had gone onto the floor”. He went back to the sink again to get more water and I said “I wonder if I moved it nearer the sink it would be better”, and Kieron said “yes, put it there” – pointing to the drainer part of the sink. I lifted it up and put it on the drainer part. He then fished out the dolls and put them in the bin. I said “I wonder why they had to go in the bin”, and he said “they need to be clean”. Then he wanted to tip the bin and its contents into the sink. I said that he would have to be a little careful and that I would help him. “No, no” he said, “please let me do it”. I said “I think it would take two of us to tip it out as it was quite heavy and that the water might make your trousers wet”. He didn’t object and I guided the back of the bin while he guided the front towards the sink.

better to ask “I wonder why that happened?” the big giraffe fell over – it was drowned. Drowning of the dolls – wanting to wash away the rubbish? Cleanse them? Kieron’s feelings of drowning under the weight of negative projections?

“He started to miss the”, spilling the water, showing the real problem of how to contain him.

He went back to the sink again to get more water overflows, uncontained, carelessness, thoughtlessness

*“he would have to be a little careful and that I would help him”* Kieron’s response “no, no...” he is challenging the boundary and limits and what I consider to be safe/appropriate. Clear boundary about the level of water given – trying to engage Kieron in remembering/linking what he is doing in this session with previous assessment sessions. Kieron remembered that he had gotten wet previously – trying to remove sweatshirt – asking for help when stuck. Managing to take of t-shirt himself. Putting animals in the sink- previous play. Ignoring my watchful words – engrossed? Deliberate?

*“but now you will be able to see me three times per week”* – Kieron smiling – Kieron registering what this means? Does that mean I can be trusted to find him? More regular contact? Does he understand this link?

Jumping activity in the room – excited at news? Or just a random activity? The hint of risk-taking behaviour – Jan Anderson doctoral thesis.

Note – need to let him know that its

I said "it's getting to the time when we have to stop for today and go back to find mum". Kieron was engrossed with the figures in the sink and didn't want to stop. I said "you seem very busy, but we will have to stop for today, and that I will see you again on Thursday". I picked up the toys and he was bent over the sink letting the water out. I said it was time to stop for today, and Kieron said that "I want to leave the figures in the bin". I said "you can leave the figures in the bin, but when they are dry I will put them back in your box for next time". I gave him his thick sweatshirt to put on and he said "it's wet", and I said "no the other one is wet, you took this one off before it got wet". He put it on and then went to the door. We walked down the corridor together.

slightly unusual to wash them in the bin

Could try saying "oh the giraffe thought he was going to have a bath – but he's under water".

His play demonstrates that he thinks it quite ordinary for there to be this sort of bath where everyone is dead, and then we all go and have a cup of tea. He is psychopathic in his behaviour. Mum needs lots of help to think about her parenting, and what she brings to their relationship. He is full of poisonous projections and we are yet to see whether he has the capacity to be free from them.

Teapot a container – bin a container – spills water – problem containing him idea of him overflowing/overwhelming adults – trying to do things 'right' but then failing and giving up – enjoying the mess?

Able to accept the idea of moving his game where it was less messy/difficult for him to manage. Able to accept my helping him so as to avert wet trousers – demonstration of understanding /logic?

Food shopping together – what sort of a meal/food is on offer are we going to make here? Apples, bananas – healthy. Stuff?? Not so healthy??

Not wanting to end – enjoying his aggressive/violent play. Figures in the bin – figures are rubbish. Wants things left the way he leaves them. Control? Wanting to be remembered? Is this ok here? Secure and Safe??

Very tiring being with this boy, but slightly better than before. Supervisory Note - give clear boundaries, and speak slowly with authority.



## Discussion (1)

In this first therapy session he paused only briefly at the door to glance at Mum before leaving to come with me to the room. Kieron's statement "*I'm a big boy now*" seemed to be his way of managing his anxiety of being separated from mum, and "bigged him up" in a way that made him feel more grown up, when actually internally he was quite possibly feeling the exact opposite. Kieron has no experience of how to really be a little 4yr old boy. Esther Bick in her paper entitled *The Experience of the Skin in Early Object-Relations* wrote about the importance of a containing objet in the infantile state and how:

*"... faulty development of this primal skin function can be seen to result either from defects in the adequacy of the actual object or from fantasy attacks on it, which impair introjection. Disturbance in the primal skin function can lead to a development of a "second skin" formation through which dependence on the object is replaced by a pseudo-independence, by the inappropriate use of certain mental functions, or perhaps innate talents, for the purpose of creating a substitute for his skin container function". (Bick, 1968)*

I had the feeling that Kieron's illusory omnipotence and pseudo-maturity that he demonstrated in the manner in which he had come to his session and in the session itself with his 'fantastic sense of self' revealed just how far he needed to go to prevent his painful feelings of falling apart and unintegration. Joan Symington (1985) also speaks of:

*This primitive basis for omnipotence is the struggle in which the young baby engages in order to survive when on his own without his Mum. (Symington, 1985)*

Writing this now, Kieron's defences could be seen as a "*healthy choice*" (Reid, 1990) in the face of the hostile devilish projections he was regularly subjected to I thought.

The way in which Kieron engages with the bin in the session does I feel demonstrate that he had gained a great deal from his assessment sessions already, in that he had at least some idea of what therapy is about, and on an

unconscious level he knew that it's got something to do with getting rid of rubbish. He makes connections but still finds it difficult, and on some level he realises that just by putting things in the bin it doesn't get rid of everything – "there's more". The idea of the therapy being a bin or a container is very interesting; the container for his rubbish. The idea of containment was, again, a very significant part of this phase of our work together. Reading through the session notes, I became more convinced that the perhaps the hide and seek games weren't simply about when he comes for therapy and when he doesn't, but maybe an indication of how he himself realised somewhere that he needed a container for his feelings and difficulties in the session and used the empty cupboard. Writing this now it occurs to me that perhaps he had a clearer idea of what he needed from his therapy than I did! He might even therefore be seen as helping me to help him by using the cupboard and pointing me in the right direction.

Willock (Willock, 1990) states in his paper *From Acting Out To Interactive Play*, that hide and seek type games represent an increasing level of confidence within the patient as they realise that:

*"...despite separation the primary object is still there and reunion will occur". (Willock, 1980).*

When looking through the session notes to write this thesis i.e. after therapy has ended, it was really interesting to see when and where Kieron changed his attention and direction within the session and to think about what might have caused this sudden change in his mental occupation. I began to wonder if there might be something linking the changes that I witnessed. I also began to consider whose attention deficit was I really experiencing in the room; Kieron's, Mum's or a mixture of both?

The second session that I am detailing in this phase is from a session that took place some four months later. Mum continued to bring Kieron regularly three times per week, and she continued to meet with the Principal Social Worker (MS) once weekly. Kieron had been attending nursery a few afternoons per week, with one afternoon taken up with visiting his new school. There were no reports from the nursery that indicated they had had any major problems with

Kieron, which was heartening on one hand, but a little confusing on the other, as Mum still reported major problems. We had negotiated our first major break over Christmas, which Kieron found particularly difficult. Mum had not brought Kieron back on the return date agreed. It seemed to take mum a while to get back into the routine of a return to therapy and school. As the therapist I also found it difficult as it seemed that whatever progress we had seemed to have made up until the Christmas break, seemed to have been completely lost when Kieron did eventually return to regular therapy in the January. For Kieron he had lost his regular sessions with me and also the containing structure of his nursery school. It seemed as if when there were no external structures in place, the family dissolved into a place of timelessness and a severe lack of containment. It was quite disheartening at the time I recall, and I wondered if there was any way this could be addressed. It took Kieron a few weeks to settle back down into the rhythm of his sessions, and his behaviour although ambivalent, seemed to settle down when this rhythm was re-established once more.

Around the time of the session detailed below, dad was due to be released from prison. There was a great deal of anxiety being generated from Mum in her individual sessions with the Principal Social Worker (MS). Her ambivalence centred on having the knowledge that Big Kieron was coming home and really wanting his release on the one hand, but on the other, she was worried about what family life would be like with Big Kieron back in the home environment. Viviane had worked hard at keeping her family together, and in her eyes, on track. There seemed to be a healthy part of her that was trying to safeguard what she had achieved on her own, and an almost more romantic and idealistic side that wanted to believe in the 'happy families' scenario she had created in her own mind.

Kieron started to attend 'proper' school more regularly at this time too, attending some full day sessions, as part of his integration process to full time school in the forthcoming September.

Process	Session	Notes (2)	Commentary
27.3.07			
<p>When I enter the waiting room Kieron is on the floor pushing along a wooden train, he looks up and smiles briefly and says to the train, "have a nice day". I go through to get Kieron's box and place it in the therapy room. When it is time I go to collect him. He sees me coming and turns and runs playfully under the chair in the corner of the room. Mum says "she's seen you running away, come on out Kieron". Kieron remains under the chair. I bend a little to catch his eye, he smiles. Mum goes over and picks up the chair that Kieron is hiding under. He looks up at her and says "Cor, you're strong", she laughs "yes I am", and he comes out and Mum puts the chair back down, and tells Kieron "go on". Kieron comes to the door but he is not running today. As he goes through he looks up at me and gives a cough (sounded like a pretend one). He walks along slightly ahead of me looking down at his feet. When he gets to the double doors he waits and we both push the door 'in time' together. His hair has been cut (again) and there are the remains of some gel on the top (spiky) but he looks quite cute but has dirty grunge on his cheeks.</p> <p>We enter the room and Kieron goes over to the cupboard saying "get the teddies; we are going to play hide and seek". I say that he wants to start the game quickly today, but I had noticed that he had walked rather slowly down the corridor today, and wonder why that is? Kieron repeats "get the teddies". I say that Kieron wants to get on with the game with the teddies. I wonder - out loud - whether perhaps Kieron has missed the teddies as we haven't met since Friday. Kieron has</p>			<p>I have to pass through the waiting room to get to the therapy room. "Have a nice day". Nice day to be back in the clinic? Pleased to see Davina.</p> <p>As I had not collected him straight away, he hides to make me experience what it is like to be left waiting.</p> <p>Noticing his strong mother, and her physical ability. Perhaps Kieron realises his own lack of physical strength in comparison?</p> <p>Slow entrance, pleased to be doing things in sync with Davina He is more thoughtful now – not so everywhere all at once – it is very noticeable. Developmentally it is good for symbolisation</p> <p>Kieron picking up the teddy game – was playing it at the end of our last session – no session gaps to be felt, just straight in and continuing.</p> <p>In and out of the cupboard, into a safe space and then emerges somehow transformed. By asking Kieron questions for reflection, Davina is</p>

climbed into the cupboard and has gotten out again, he has his arms over the top of the doors and he looks at me and says, "I'm knackered" (he looks and sounds quite comical). I say he's knackered, and he says yes, "I'm knackered". I say "I wonder what that means", and Kieron replies saying, "I am knackered but my mum isn't". I say that Kieron is letting me know that he feels knackered today, but mum still has lots of energy left. I say that maybe Kieron wonders if Davina has any energy left today. "You come and find me teddy" he says, and climbs back into the cupboard, "count" he says. I say that Kieron wants me to count. "One two three" (Kieron holds up his fingers on one hand as he count), then one two three five (holds up fingers on his other hand).

I count as Kieron has asked and then say that "You want teddy to find you – maybe Kieron thinks that teddy has forgotten him since Friday?" Kieron doesn't reply. I sit teddy puppet on the cushions next to the cupboard and say aloud. "Mm... today Kieron has come into the room more slowly... he wants to play the hide and seek game with the teddies, and he's feeling knackered..... He wants to hide, but he wants teddy to find him. I think Kieron wonders where teddy has been the past few days." I hear Kieron clear his throat. "What's that noise teddy says?" Kieron giggles in the cupboard. Teddy says "I think Kieron is hiding in the cupboard", just as teddy goes to open the cupboard Kieron opens one of the doors. Teddy says, "oh, what a shock; one of the doors has burst suddenly open". The other door follows and teddy says that "now the other door has opened". Teddy looks around the door edge at Kieron

slowing him down nicely

Perhaps a link here to mum's physical strength demonstrated in reception. Perhaps Kieron is letting Davina know that he isn't as strong as he would like to be. His anxiety re dad coming home and the changes?

He has a real pleasure in my looking for him and for being found

Kieron coughs to make sure that he isn't forgotten. Perhaps Kieron is impatient with me for talking too much? Kieron has to be the one to give the surprises.

Kieron showing me that he is still getting shocks and surprises– surprises and the unexpected in his life. Outside some of these he cannot control, but in the room he can be the one causing the shocks. Possible sadistic pleasure/excitement in inflicting shock and surprise.

Someone is missing? Someone needs

<p>who is laughing.</p> <p>Kieron says “where’s your brother?” Teddy says he’s not sure. Kieron gets out of the cupboard and starts looking for Teddy’s brother. He looks around the room and then says, “I know” and goes over to his box. I say that “Kieron thinks that hedgehog might be in his box”, as Kieron puts toys on the floor (drops them). He finds the teddy bear (mum) and throws it to me saying “here’s your mum”. I say that “Kieron wants me to have all my family with me”. He looks up and says “there’s hedgehog– he is on the shelf still”. I get hedgehog down and I sit down with the bear family and Kieron says “I’m going to hide under your seat and teddy has to find me”. He wriggles under my seat and I say that Kieron is hiding but wants teddy to know exactly where he is hiding so that teddy can find him. I think that Kieron is hiding but wants teddy to know exactly where he is hiding so that teddy can find him. I think that Kieron is letting teddy know that he wonders where teddy has been for the past few days, perhaps Kieron has missed teddy. Kieron is under the seat and doesn’t reply. He pokes my leg gently and I pretend that I am surprised (he has done this previously). Teddy looks under the chair and announces that Kieron is there. Kieron growls at him, and I say that Kieron is growling at teddy and Kieron does it even louder. I say “that growl is even louder”. Kieron comes out and puts his face to teddy’s and says that he is only pretending, and nuzzles up to teddy’s nose. I say “Kieron is only pretending and teddy doesn’t really need to worry about Kieron’s growls”.</p> <p>Kieron sits on the chair next to mine and says “I need to see my mum”,</p>	<p>to be found? Not Kieron this time.</p> <p>Finding family members, gathering together of a family – dad’s return coming into Kieron’s play here.</p> <p>Wanting to get right inside me today</p> <p>Poking me – annoyance at the break. Growling teddy, letting me know that he doesn’t like missing sessions. Perhaps not yet familiar with therapy pattern. May be annoyance that dad will be coming home too?</p> <p>Bark worse than his bite? possibly</p> <p>Anxious about growling – showing his anger? Frightened about retaliation from Davina? Possibly angry that his mum hasn’t brought him? Kieron feels suddenly small – theme running through the session.</p> <p>Doesn’t want to experience the feeling</p>
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and I say that "it's not time to see mum yet". Kieron does not stay with this request. Kieron says to teddy that "it's your turn to hide and I will find you". "Hide him under the seat" says Kieron. I say that "Kieron wants to know exactly where to find teddy". I put teddy under the chair. Kieron counts and then looks under his own chair (hangs over the side with head down). Davina says to be careful, as he might slip and hit his head. "I'm fine" he says, and then says "teddy isn't there". He looks under the chair again and says "there you are teddy". I am hanging onto Kieron's trousers and repeat that "I think it would be better if you were up the right way", he is hanging upside down. He eases himself to the floor and I see that his hip is bruised. I say "you have a bruise" and Kieron turns his head to see and says "I hurt myself" and says "my head my arm and my leg in my room". I say that Kieron is letting Davina know that sometimes when he is not here he does hurt himself and doesn't always realise when he could get hurt. Kieron gets up and looks at me and says "I need to go to the toilet". I get up and he says, "no you stay here", I say "I will go with him to the toilet, but that I will wait outside for him to finish".

As we go down the corridor he says "I want to go in the man's one with the chair" (disabled toilet). I put my foot in the door (as the lock is on the inside) and Kieron says that "hey I want to close it". I explain that I do not want him to lock himself inside so I will wait at the door. He goes in and I hear him go to the toilet and flush it. I hear him run the water and pull the paper towels. He comes out and says to Davina, I need tissues for my nose. While Kieron is speaking someone (colleague) has gone into the toilet he came out of

of not being able to find Teddy – and again theme of not wanting to feel small.

He has done the bruise to himself – sometimes this has happened in the room with Davina. No doubt his activities are not being monitored by mum or anyone else.

Unhappy with Davina's comments about him not realising when he could get hurt- needs to evacuate.

Kieron wanting to control Davina

This toilet is larger inside, (he wants to be bigger) but also wonder whether Kieron is showing me about something in him that has been disabled/ isn't functioning right – link to me also a possible cover up for feeling so small at times today. My comments about him not realising when he could get hurt making him feel disabled – i.e. that he might be doing something wrong?

Again Kieron wanting to control the opening/closing of the toilet door.

(the other toilets are blocked). I go into the ladies and get some paper quickly; meanwhile Kieron goes into the men's toilet. I say "I have toilet paper" and he says "it's not toilet paper" as I hurry him out of the blocked toilet.

We walk back to the room and Kieron is picking his nose, and trying to wipe it at the same time (it isn't running). He gets back in the room and sits picking at his nose. He says "I went to the school today", I wait. He says he hates school, I say "I wonder why he hates it today", and he says that his friends punch him and kick him and grab him around the throat until it hurts. I say "that doesn't sound very nice". I ask whether he has told anyone, and he says "Julie". I say "is Julie a teacher?" And he says again "Julie". He says "they don't do it to Ricky", and I say that he is wondering why they have been nasty to him, when they don't do it to Ricky. (I find myself wondering whether Ricky is a bully while Kieron is speaking).

Kieron gets up and goes over to the box and gets out the bike saying "I know Davina let's play with the bike", he then adds "here is the police helicopter too". He says that he will be the bike and I can be the police helicopter. He puts the helicopter on the chair arm of my chair and goes over to the table. He moves the bike around and around the table and I comment on what he is doing. He stops and parks the bike, and then manoeuvres it so that one of the wheels is almost over the edge, it is balanced. I say "Kieron is moving the bike around and around the table but he is being very careful not to let it fall off, he has balanced it right on the edge". Kieron starts to move the bike around again – around and

Something up Kieron's nose - trouble at new school?

Telling me something important /serious here. Describe what he has said, show that you have heard him, and acknowledge that he wants to move onto something else.

Changes direction – wants to move on.

Kieron letting me know that he doesn't want to say any more about it today – wanting me to hold onto it for him. Kieron is wanting to do something different/think about something different

Davina is to be the police helicopter – watching/hovering to see what happens.

There is a sense that something quite dangerous/lethal is happening here, something final



around when he gets close to the table edge again I say "that was close". Kieron looks at me and says that "if it goes over the edge it will die". He comes over and gets the helicopter. I say "I wonder what Kieron is going to do with the helicopter" and as I watch he lets the bike fall over the edge and then brings the helicopter down to stop it from falling. "Oh I say, the helicopter has saved the bike from falling". Kieron puts them both on the table and then hits the bike with the helicopter and it falls to the floor, then he throws the helicopter across the room so that it lands in the corner (nowhere near me). Kieron goes to get onto the table and I say, "what has just happened there? The helicopter saved the bike and then hit it so that it flew off the table onto the floor, then the helicopter flew across the room. I wonder why the helicopter did that". Kieron looks at me but says nothing. He then lies across the table. I say to be careful on the table as he knows it only has three legs. Kieron's head is on one side and his feet on the other. He is looking at his feet and saying, "now I see them", then raises his feet and then says "now I don't". I say that I wonder if he is wondering what happens when Davina doesn't see him. What does Kieron think happens here when he is not here? Kieron ignores my comments and continues to lift one foot and then the other. He says "you sing five little sausages frying in the pan". He recites some of it and I recite a bit too. (I am wondering what goes bang when he isn't with me – the bumps where he hurts himself.) Then Kieron says "my head is in the frying pan". I say "oh no his head must get out of the pan, it will be far too hot!" Kieron turns and says quietly, "you must help me". I say

The anxiety is too much for Kieron – it's terrifying. He does hope that I can be a good daddy helicopter who keeps a close eye on him when he's close to the edge

Kieron has moved out of identification with Spiderman – more aware that the world is a much more frightening place – he is showing me that he is much more vulnerable and small today and that he needs help.

The limits of what daddy/mummy helicopter can do to help are also indicated here – having saved the bike, it then hits it. So there is still some danger around for Kieron. Perhaps an unconscious angry realisation that when he gets hurt he is on his own. Perhaps he hasn't moved that far from talking about being hit at school after all. Perhaps this is what Kieron would like at school – someone to watch over things when they get out of balance?

Hard for Kieron to come and be helped and then not to be seen (dropped) – feels like a good thing, but then turns into something painful

Perhaps he is struggling with not being able to stand on his own two feet. Sometimes he sees this, and at other times he doesn't and it's painful for him to feel so small.

Controlling me – a song from school? This nursery song is about things going bang and then things disappearing. Following on from the helicopter being thrown across the room, this might be Kieron's experience of being left alone and having to stand on his own two feet, and just how hard that is at times.

Would not have dreamed that this would

that "Kieron wants Davina to help with some of his hot feelings that he has that he doesn't understand."

Kieron gets off the table and says "where is my rocket?" He goes over to his box and I say he is looking for his rocket in the box (a drawing that he asked me to make a few weeks ago). I say he has remembered his drawing and he says the words, "yes I membered" but doesn't say remembered quite right. I say "it is almost time for us to stop for today". He says, "oh!" As if he is surprised. He smiles as he lays the picture on the table. Kieron says he wants to be a rocket, and gets the red marker pen out and fixes the red lid to the bottom of the pen. I say he has fixed the red cap on the end – it now looks like the drawing of the rocket with the red fire at the bottom. (As I'm typing this I am thinking now about Kieron's hot feelings going off like a rocket). He aims the rocket for his head, and I comment on what he is doing. I say that the rocket is coming towards him, and to look out for the tip in case it hits his eyes. He smiles and continues to move the point towards his head. He repeats this several times. I say "there is a part of Kieron that wants Davina to be worried about the pointy bit at the end of the pen, and what it might do". Kieron continues. I say he is being careful that it doesn't hurt him, and he suddenly puts a dot on his forehead saying "I have a red spot now". I say "you have a red spot on your forehead but it hasn't hurt you". He does it a second time quickly. I say "we have to stop for today now". He puts down the pen and walks over to the door and unlocks it. As we walk out he says "can't I do the big door today" and I say that I will do it. He says "I did it last time", and I say that "he did it a long time ago now and he

be seen from Kieron two months ago – he is so much more vulnerable – Kieron sees me as someone who he can rely on to help him deal with his hot headed feelings. Perhaps it is his jealousy pushing him over the edge – doesn't want to share me with others when he isn't around, doesn't want to share mum with dad, or share his friends

Kieron's world being rocked on many levels at the moment – dad coming home, sharing mum, sharing me, friends Hot headed – aims rocket at his head – didn't have space to think before, now he notices things, can process, emulates my play – is he under here etc

Seems pleased that I am trying to prevent him hurting himself

His head very at risk at moments of high anxiety – aims rocket carefully – less hot headed than he was certainly, has a bit of punctuation himself, much more aware of risks now

Beginning to spot things/notice things in a way that I have, and he can now verbalise them too

Still wanting to be the grown up outside session – door fob.

Returning to mum relaxed, but gets anxious when dad isn't there to meet him. Perhaps confused about where his mum has been while he has been away. Confusing mum with Davina mummy?

Much slower and much more vulnerable boy in the room today

still remembers". We walk towards the door and he goes out to meet mum. She smiles and Kieron says "where's my mum? Mum says what do you mean where's my mum, I'm here silly. You mean where's my dad?" She smiles at me and I smile and say "goodbye, see you on Thursday". "Say goodbye Kieron" she says to him, and he turns and says "bye". I turn and return to the room, feeling that he has been much calmer in the session today again.	
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## Discussion (2)

This session demonstrates how much that Kieron can now put into words, his anxieties are very apparent, and so too is the idea that there is someone there in the room with him that can help him think about what is going on for him. What really stood out for me when re-reading this session for this phase was the real sense of Kieron's dawning of awareness that he wasn't as omnipotent as he believed himself to be. There is a real sense here that Kieron was struggling to come to terms with this realisation i.e. that there are people, bigger, stronger, more able, and bullies too, which appear to be increasing his anxiety levels. His ego is struggling to find a real place, not an imagined place that he believes in, but a sense of his own male potency; "where's my rocket?"

Freud (Freud, 1926), speaks of expressions of anxiety in small children which are intelligible to us which can be reduced to a single source – *'missing someone who is loved or longed for'*, and he traces the anxiety back to a stage in which the immature individual was entirely dependent on its mother. Perhaps there is a glimpse in this session when Kieron asks to see his mother, of him getting in touch – albeit unconsciously – with some very destructive thoughts towards her, and seeking to see her again to prove that she hasn't been destroyed by his growls. Alternatively, or similarly, he might also be concerned about a reciprocal attack from me when he growls at the Teddy. Whichever is the case, there is an anxiety for Kieron around being angry and expressing his

anger towards someone that he feels dependent upon just in case they are killed off in reality just as they are in Kieron's internal phantasies. Maybe the anxiety involves the loss of his mother, me in my absences, and his father's imprisonment and longer term absence that Kieron has experienced. Klein, in her chapter 'Early Anxiety Situations', states:

*"...the ego of the small child is burdened with the conflict between the super-ego and the id as well as with the conflicting demands of the super-ego itself which contains various imagos that have been formed in the course of development. In addition to all this the child has to cope with the difference between the demands of its super-ego and those of its real objects, with the result that it is constantly wavering between its introjected objects and its real ones – between its world of phantasy and its world of reality" (Klein, 1932),*

The inner turmoil that Kieron expresses throughout this session is that of not knowing where he fits in to the bigger picture. He has no doubt heard that his father is returning home soon – mum's comment "you mean where's my dad" gives an indication that Kieron has at least some knowledge of his return – but he is unsure what this will mean for him in reality. There are bullies at school, there is mum showing her prowess at physical strength, Davina says he cannot open the door with the fob, and there is Kieron struggling to find out who he is and how he is to behave. His recognition of me as someone who can think about things and maybe help him understand things was very touching in the room, but I have to say it was even more powerful re-reading this some years later when writing the thesis. It almost felt desperate when I re-read it, "You must help me". His hot head feelings might lead him into trouble, the internal struggle between retaliating to his external bully being checked by his internal super-ego bully seems to be quite clear here. It was also noticeable that perhaps he hadn't moved on from his original important disclosure re the bully when he changed the play – another layer that I had not picked up in session. This was Kieron at a very vulnerable stage, he seemed to be internally conflicted and in a great deal of pain. This again, was something that I hadn't been aware of in the session or afterwards when writing up the case study for my qualification paper. Perhaps my ability to make links has improved over the

years of experience that I have now had since my meetings with Kieron – I would like to think so. What I have found fascinating is the development of ideas and thoughts that appear to change and re-form to reveal another layer of meaning and insight.

### **Phase 3**

In this third phase I will again be detailing two sessions where it can be seen how Kieron has moved on from his original psychopathic position in relation to another person, into a more 'normal' way of interacting. I use the term psychopathic in the sense that Kieron appeared unfeeling and insensitive in relation to others, he seemed to lack empathy. He had killed pets, with no guilt or concern for his actions, and his overall general impression of being omnipotent combined with a lack of control. When the first session presented in this phase took place, Kieron was 4yrs 8mths old. He had been in intensive psychotherapy for 7mths.

At the time of the first session detailed below, Big Kieron had been released and was living in the family home. He often brought Kieron for his sessions, and it has to be said, when he did so Kieron always wore weather appropriate clothing and there seemed to be a very close bond between them. I mention this because there were times when Kieron was brought by his mother during the winter months with inappropriate clothing – the coat was very thin, and hats, scarves and gloves were not evident. Sometimes Dad would attend the weekly meetings with the Principal Social Worker. In the two sessions in this phase, I have chosen sessions which I feel clearly demonstrate how Kieron really begins to engage in much more imaginative play. He is increasingly present in the room in a more contained and thoughtful way and he is able to allow himself to really connect with Davina. His ability to listen and follow instructions is highlighted here. He feels comfortable enough to ask why questions. He also expresses in a confident manner a need for appropriate help without ordering me around. His tone and way he related during this phase was significantly different - it didn't feel bullying or aggressive – more like a reasonable asking and normal interacting.

What are still exhibited here are Kieron's anxieties around our meeting and not meeting, but what is much more apparent is his vulnerability which he has allowed to become more visible and known in the room with me now. Also, Kieron's nervousness when there is a potential conflict between us is invariably managed by Kieron instinctively whereby he instantly reverts to old familiar play. This was particularly noticeable when he was offered an explanation by me that questioned his own beliefs and usual mode of interacting. Once he feels he is on safe ground and we are interacting again, he feels contained and in his mind no conflict exists – we are not separate but united once more. Interestingly enough, the sense of him manically charging around the room trying not to fall apart or the sense of his previous 'tough nut' exterior to cover over any anxiety is not experienced as being present in the room.

<b>Process Session Notes (3) 29.6.07</b>	<b>Commentary</b>
<p>When I went to get Kieron he was again sitting with mum – he was on the floor kneeling up to the sofa next to mum playing with a small car. Mum stroked his head as I appeared at the door, Kieron heard the door and looked up and got up immediately and smiled. He walked towards the door with a determined look. We walked along the corridor side by side and Kieron pushed the door and I followed him through.</p> <p>At the therapy door he opened the door and walked through and went straight over to his chair and sat on it with his back towards me again. He was lying on the chair with his knees bent up, I watched as he tapped his foot a few times on the chair. I looked at my watch and he was silent for about 30secs before he giggled and got up and walked around the back of his chair. He hadn't spoken and neither had I. He pushed his chair from one end of the therapy room to</p>	<p>For Davina's benefit?</p> <p>Different start to the session.</p> <p>Davina waiting to find out what is happening in the room today</p> <p>When Davina doesn't see Kieron over the weekend break, it really hurts him and he feels abandoned and attacked. Back towards Davina, silence crashing the chair, then everything is put back where it was and then he starts the session. Shows how peed off he is, and then gets on with it.</p>

<p>the other – crashing it into the cupboard. Still neither one of us spoke. Then he turned it around and pushed it back to where it had come from. When he reached the other side he looked at me and said “let’s play hide and seek” (Kieran’s pronunciation of the hide and seek game). I look at him and say that he has come into the room quietly and has sat with his back to me today on his chair, without speaking. Then he has pushed his chair backwards and forwards in the room crashing it into my cupboard. Kieron is listening to what I am saying, he is staring at me. I say that now he seems to have settled into the room and now wants to play hide and seek.</p> <p>Kieron grins and goes over to the sink and hides underneath it. He says that he is hiding and that I’m not to count and I’m to look everywhere. He tries to pull the chairs back under the sink to block him in, but they do not fit. “Blooming chairs”, he says pulling them under unsuccessfully. I say that “the chairs are not doing what Kieron wants them to today” and Kieron said “yes, they don’t fit”. He then adds that “maybe one will. He pushes them both out and pulls only one back in. I say that Kieron has thought about it and has decided to try with one chair only, and that seems to have worked. Kieron says “can you push the other one in please”. I say that Kieron wants me to try to put the other chair back under. I get up and cross the room and gently slide the chair back into position.</p> <p>Kieron finds a ball under the sink and says “where did it come from?” “Perhaps Kieron thinks that he is the only person who comes here and uses the room” and Kieron says “yes” quite emphatically. “I can keep it he says”, I say that he thinks that because he has found something it means that it is his.</p>	<p>Kieron can see and hear that Davina is thinking about things in a different way i.e. without shouting.</p> <p>Davina explaining what has happened today. Kieron is attentive. Attack on the cupboard – frustration? Hide and seek – comforting familiar play from previous sessions</p> <p>Controlling Davina– maybe still anxious and annoyed</p> <p>Kieron frustrated, but able to think about what is happening and to talk about it, and try different things to make it work</p> <p>Asking Davina for help nicely when necessary</p> <p>Realisation that someone else has been in the room, but still wants to believe he is the only one. Shock of finding ball – idea of sharing Davina or the room is inconceivable</p> <p>Davina comfortable being in charge, thoughtful about what is said and how</p>
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And Kieron says “my mum says.” but drifts off. I say that “Kieron has a ball in his box, and this ball is not for Kieron to play with”. I pick it up and put it on the top shelf.

Kieron repeats that I am to “look everywhere, but not to count”. I say that “Kieron is keen to tell Davina again what she must do and what she mustn’t do”. I sit on my chair and look around the room, both of us are silent. I know that Kieron is watching me. I look under the chair with my eyes, and look in the cupboard, I look under the table, and over to where the cushions are. I say eventually after about 30 seconds or more “I feel I am being watched”. Kieron laughs and I feign surprise and Kieron starts to giggle saying “that was funny, again. I want to do it again”. I say that he seems to like making Davina jump, and he laughs and says “yes, again”. We repeat this game twice more, and I say that I think that Kieron enjoys the game and that I think there is a part of Kieron that wants me to know what it’s like to be surprised and a bit scared.

He is still under the sink and says, “can I touch this?” (Pipe under the sink). I say that he isn’t to touch it because if the bits come lose then the water that goes down the sink could flood the room. I add that he can watch as the water goes down the sink if he wants (recalling his previous experimentation) but he ignores my offer but doesn’t touch the pipes any more. He gets out from under the sink and says “my willy is stick” and I say “do you mean it’s hard?” and Kieron says “yes”. He pulls at his willy through his trousers. He goes over to his box, and drops things onto the floor randomly and I comment that he has dropped them onto the floor without thinking. He says “where are the bikes?” I say “they are not in the

she reacts

Fun game, where Kieron can shock Davina and then laugh- he enjoys the game and wants it to be repeated

Kieron asking permission.  
Touching pipe – penis. Inside the mother’s body. Where does Davina’s authority come from? How can Davina be a mother and a father? Kieron puzzled

Being under the sink (confined space) arousing feelings of excitement? Or the idea of flooding the room? Perhaps there is something about asking permission and having things explained that Kieron enjoys?

He doesn’t answer but able to say what he is looking for – is thinking but not about the dropped things – focussed on bikes



box", Kieron says "I'm going to tip it out" and I say he can tip it out on the floor but the bikes are not in there. "Why?" He asks, and I say "they are broken", he says "they can still be used". I say that he thinks they can be used even though they are broken and he says "yes".

He picks out the elephant saying "here's the little elephant", and then says "you be the little elephant and I'll be the big one".

"I'm bigger than you" he says, and I agree that he is. "I've got a bigger nose", before I can stop myself I say "yes you have a bigger trunk", and he says "yes". I say that "Kieron wants me to know what it feels like to feel small" and he says, "now you can be the big one and I'll be the little one". I say "Kieron wants to swap now, and he can see what it is like to be a baby elephant". He walks the elephant up and down on the arm of the chair. He goes over to the box and brings back a horse saying, "now here's a black horse, and the baby elephant and the horse say hello to each other", and Kieron says "how are you today?" in a voice of the horse, then Kieron replies "I'm fine how are you today?" in the voice of the baby elephant. He then replies "I'm fine" in the voice of the horse again. "I can get on your back" says the baby elephant. He tries to put them together with the elephant on top, but they keep falling off. "I need sellotape" he says. "I say he has used it all, but maybe there is something else he could use?" He goes over to his box and says "how about this and holds up an elastic band". I say "I think that will work very well, Kieron has thought about what he might need and has found something that can work". He brings it over and asks me to hold the horse and the elephant and puts it carefully over them both, then says "can you do it?" I say "Kieron

As bikes unavailable, changes toys to elephants

Broken toys, damaged toys. Sense of him being broken and damaged but still functioning. Don't discard me plea from Kieron – I want to be bigger

Kieron has taken such a leap in the last month. Kieron in an excited state inside – elephant – you be small and me be big and then reversed. My willy is bigger than your willy – Kieron experimenting with his idea that he has a smaller willy – new play. Able to swap roles

What is becoming built is a notion of a helpful object. If you are in the mind of a thoughtful object for a time it's not too awful – he can have his own potency too.

Role reversal position in Kieron's play is a new development. A game that is added to (horses etc) and not just off onto the next thing

How are you? Kieron showing that he understands that Davina is interested in him. Introjecting a benign object who isn't trying to cut off his willy and humiliate him. Normal good mother/baby relationship

Kieron able to use my suggestion. Kieron thinking and finding a solution himself. Asks and accepts help where necessary. Does Kieron want to be fastened to Davina symbolically?

He has to fly – he can't take it for too long. Not grounded here

<p>wants me to make sure that the two are fastened together securely". He marches them up and down the arm and then flies them up in the air saying they can fly, and I say that "they are flying together". He puts them down on the arm and then he goes back over to the box and holds up the giraffe and says "now you can be the giraffe" he says. I hold the giraffe and the horse/elephant. "You say hello and compare heights – you are very tall, but I am nearly as tall". I say that it is important for the small elephant to have someone to help him feel bigger than he is.</p> <p>He goes back over to the box and brings back the little boy. He brings the boy to rest on the arm of the chair and walks him up to the giraffe and tells the giraffe "I love you", and I say that the little boy loves the giraffe. Kieron brings the boy up to the giraffe head and kisses it, and I say "the boy wants to be close to the giraffe and wants to kiss it". Kieron is smiling.</p> <p>He goes over to the box and brings back a cup which he says "this is a trampoline". He bounces the boy up and down on the trampoline and the giraffe watches the boy. Then he hides the boy under the cup and says, "look everywhere". I am the giraffe and move the giraffe around the cup looking. Kieron is pleased that the giraffe is trying to look around the cup, and over the cup and tapping on the top of the trampoline. He moves the cup and the boy falls to the floor and Kieron says, "you are sad", and I say "the boy has fallen and Kieron wants the giraffe to be sorry to have lost the boy". I say "I think that Kieron wants to know that Davina misses him when he isn't here". He repeats this again, and says again, "again, do it again" (but not in an unkind way, more in a way of a younger child). We repeat</p>	<p>Comparing heights/ lengths/ sizes. (pipe/penis). Giraffe is being Davina–combined object mummy Davina with internal penis</p> <p>Game is developed with more characters – giraffe and boy added to the play</p> <p>Kieron showing that he loves Davina? Wants to be close? Can be tender, and can express his affection</p> <p>Game extended again – now a cup (trampoline) is added Connection to parents' new sexual relationship?</p> <p>Kieron actually does feel that he gets knocked back when he doesn't come to his sessions – it hurts his feelings, he is sad – that is why he turned his back on Davina at the start of the session? Cup is a container, when Davina is absent Kieron feels he is uncontained and lost</p> <p>Kieron likes to be admired, and really wants to be wanted and missed – the repetition of the game is a part of normal child development</p> <p>It would be helpful to introduce a calendar for Kieron with colours showing which days he comes and which days he doesn't come to the clinic to help with his clarification.</p>
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the scene over again, and Kieron looks happy.

I say "Kieron comes to see me here and then other days he doesn't come here, and perhaps he is a bit confused about what days he is coming and when he isn't". Kieron says "you knock the boy over and then say sorry". I say "I don't want to hurt the boy", and Kieron says impatiently "do it" to block out my voice. I say "can I just say something Kieron?", and he shakes his head and rolls his eyes a bit and says "go on then". I stop myself from laughing and say "I could knock the boy over deliberately, but then I wouldn't really mean I was sorry because it wouldn't be an accident would it?"

"Let's play hide and sink" he says, and goes over to the cupboard. He pulls it open and takes out a piece of sellotape and paper that is stuck inside and says "what is this?" I say "I am not sure what it is", and Kieron gets inside the cupboard, and then says, "no I want to go inside the other one". I say "he feels that he wants to hide again, and I wonder why that is?" He tells me to "look everywhere". I say "it is as if he is lost and really wants me to find him". "Look in the cupboard over there" he says pointing to the cupboard near my chair, I say "Kieron is very keen to tell Davina where to look, but not to find him too quickly", "and don't count" he adds, and I say "Kieron doesn't want Davina to count this time". (I find myself thinking about the previous session when he got very angry with Davina about numbers and wonder if he cannot count as well as he would like to be able to either).

He gets in the other cupboard and

Kieron showing me that he is vulnerable when he doesn't come to sessions. He speaks over me. Kieron impatient with me, but still able to listen – quite comical –but important not to hurt the boy in the play. Kieron accepts this, he reverts to his safe play – when he comes and when he doesn't again

Back to familiar play. Needs to be contained – feels anxious re comments of not meaning what you say?

Has there been an intruder? He goes in the cupboard that hasn't been intruded upon. Threatened/unsettled by evidence of someone else being in the room (ball and now sellotape). Wants to mark new territory, feel special?

Kieron responds to my comments here again

As Kieron drops his omnipotence can see he is a sensitive child who doesn't possess me. I am not a glove puppet. Not so much hide and seek, but wants me to want to find him because he is hurt. He wants confirmation that I would go to any extreme lengths to find him. Demonstrating that I care about him enough and notice when he isn't there.

Numbers make him feel insecure and more vulnerable – representing a threat?

Kieron asking me to help. Kieron listening to what I say about not locking the door. Doing things together

Listening and responding

Feet not needing protection, he feels

<p>says “can you shut the door please?” I say “I think Kieron can shut the door himself” and he does. I say “Kieron isn’t to lock the door when he’s inside”. Today he listens and doesn’t lock it. He says “can you shut the other door please”, and I say “I will shut the other door, now we have shut the doors together”. He opens his door briefly and says “I need to take my shoes off” and pulls off his trainer – they are tied with laces – and throws it into the middle of the room. I say “you need to be careful where it lands” and he removes the next one and doesn’t throw it nearly as far. I get up and pick up his trainers and undo the laces and loosen them for when it is time to go. Kieron is inside the cupboard. He makes a noise and says “what’s that noise”. I say “Kieron wants me to hear him, and wants me to wonder where he is”. He gets out and pulls at his trousers again saying “my willy is stick”. I say “you mean it’s hard again” and he says “yes”. He gets down on his hands and knees and covers his head and slides along on his legs and hands towards me saying, “you say, what’s that?” I say “Kieron wants me to wonder what it is that is sliding towards me over the floor. I say it seems to be heading for the cupboard”.</p> <p>He comes over to the cupboard next to my chair and gets up and says “let’s play McDonalds”. I say “you want to feed Davina now” and he says “yes”. He gets inside the cupboard and closes the door and then opens it and asks me “what do you want?” in a friendly manner. I say “what have you got?” And he says “ice-cream or fruit?” I say “what shall I have” and he says “banana”. He hands me a banana and I pretend to peel and eat it. Kieron watches and grins. He gets out of the cupboard and says “I’ve got lots of fruit, apples, oranges, bananas,</p>	<p>safe – cupboard protecting him?</p> <p>Parents’ intercourse- night time noises – he is in the dark. I am to be curious – just as he is at home. Links to earlier pleasure at making me jump</p> <p>Kieron wanting to be found – willy stick – pleasure at being found again? Would perhaps have been helpful to acknowledge his pleasure here.</p> <p>Plays McDonalds game – giving me fruit, enjoys the game, laughs</p> <p>He <u>is</u> playing – such an achievement for this boy</p> <p>Giving me healthy food – fruit. Internalised good breast/good food from me and wants to reciprocate Feels he has lots of good things to offer</p> <p>Kieron showing me that he wants to be more of my boy – not psychopathic any more. He is really playing which is lovely to see and hear</p>
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<p>oranges, and pears” he pauses and adds, “what do you want?” “What do you suggest” I say, and Kieron says “oranges”, I say “oranges please”. Kieron says, I know, my shoes can be the oranges. He puts them inside the cupboard and then brings them out one at a time and says, “here you are” and hands me his shoes. “Oh I say, these are interesting oranges, I wonder how they will taste?” And Kieron laughs. I say “it is almost time for us to stop for today and we have to pick up all the toys as well as get Kieron’s shoes on”. I get up and start to pick up the things and say “are you going to help me today?” and Kieron says “yes”. He gets up and we both put things into the box. Kieron sits on my chair and holds out his foot I say “there are just a couple of more things to go in” and put those in first and then go over to Kieron’s waiting foot. I notice that his socks are inside out. As I put the second one on and tie it the laces are uneven. “Why is that like that?” Kieron says, and “I say one side of the laces is longer than the other”, I remove his trainer and try to level them up. Kieron says “thank god, that’s not swearing is it?” I am busy with the lace aware that we have slightly over run and say, “no that’s not swearing”. Kieron says “my friend Aran said fuck, and that’s swearing isn’t it?” I say “yes that that is swearing but it’s ok to say thank god”. I complete the trainer lace evening out process and say thank goodness, and Kieron says “thank goodness” and smiles. He gets up and says again, “my willy if stick again”, and I watch as he rearranges his trousers at his crotch. I say “your willy has been hard again, and seems to have been hard a few times today” (I don’t know what else to say!).</p> <p>We walk down the corridor together and mum is waiting for Kieron and</p>	<p>I am asking and Kieron responds positively. He is enjoying doing things together – collaborative idea of a relationship working</p> <p>Kieron beginning to question things – wanting an explanation</p> <p>Checking out with me what is right and wrong behaviour, what’s ok to say and what’s not</p> <p>Much more the boy of the therapist – wants to be the thinking boy</p> <p>Willy stick - pleasure at feeling close to me – smiling when he repeats ‘thank goodness’ – connecting</p> <p>Kieron mirroring me, introjecting my words</p> <p>Kieron’s pleasure at being with me and of feeling that he is getting things right – internally makes him feel good and externally gets an erection. Acknowledgement of his pleasure might have been helpful but not available to me at the time.</p> <p>Leaves the session walking</p> <p>Kieron wanting to take something when he leaves the clinic – to hold on to? Seemed like it could be anything as long as he has something to take away</p> <p>Anxious about leaving, concerned that other children will be seeing me when he doesn’t. Wants to take away something physical that is good, worried about managing until the following session.</p> <p>Kieron responds to my way of thinking easily</p>
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<p>smiles as she sees him coming out. I say "goodbye and see you on Tuesday". Mum says "yes, see you next week". Kieron goes over to the sofa and picks up a car saying "I'm going to take this home", mum says "you can't take it home", but Kieron is holding it firm. I say over my shoulder as I am going back to the room, "you have to leave it here Kieron otherwise it won't be here next time and then you won't be able to play with it". He puts it down immediately and moves towards the door, mum looks at me and smiles and they leave. I walk down the corridor wondering whether I said the right thing – not wanting to undermine mum – and then think perhaps it might help her to explain "why" to Kieron when she usually just says no (my hope)</p>	
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### Discussion (3)

This session can be viewed as signalling the many ways in which Kieron has learned to trust that I will be a reliable, robust and strong role model, and perhaps one that he feels he can rely on to check things out with and question. He comes across in the session as being far less the overconfident, 'cocky' boy, but more of the inquisitive boy, wanting to learn what is acceptable behaviour e.g. 'that's not swearing is it?' This can be seen to indicate a shift in his own self perception where he is no longer uncaring about others, but much more interested in forming an alliance with another. He wants to get it right in an enquiring and inquisitive manner as if to somehow check out for sure (by asking me directly) what is right from wrong. What is important here is the sense that he wants to use me as a role model for his workings out, and that he has internalised something good that he feels that I represent to him in his sessions. This is even more interesting when we consider his father's fairly recent release from prison and the police involvement that was still occurring externally in his home environment. In the session detailed above, there was a feeling in the room that Kieron had indeed received something from his loved object in the room and he wanted to keep it inside him, and asking for clarification is his way of showing his gratitude to me for being there.

*“A full gratification at the breast means that the infant feels he has received from his loved object a unique gift which he wants to keep. This is the basis of gratitude. Gratitude is closely linked with good figures”*  
*Klein (1957)*

In his play here Kieron is giving me good food to eat, not rubbish. There is a real notion that he feels nourished in his sessions, and wants to give this back by feeding me, as a means of demonstrating his gratitude. There is real warmth of affection here, and a genuine wish to show his pleasure. Another way in which his pleasure is shown in this session is with his “willy getting stick”. There is also an undercurrent of sexual feelings and urges both in phantasy and physically in the room in this session – the noise in the cupboard (parents’ love making noises at home?), his willy getting stick, I’m bigger than you, touching the pipes (penis) – that could easily be viewed as having a huge connection to his father’s return to the family home- this event had made a very significant change in the family dynamics for Kieron. He had heretofore been the ‘man’ of the house in his mother’s eye, and he had been usurped from Mum’s bed by his returning father.

The feeling that there had been an intruder in the room also shows a degree of tolerance in Kieron that seemed absent in his earlier omnipotent phases. He still wants to be ‘the only one’ and feels he should be the most important one at the very least. There is a sense that Kieron has developed a tolerance of ‘a third’ person in the room, he shows the beginnings of acceptance that other people may come and use the room when he is not there. Having said this, he does in a way, mark his territory by choosing the cupboard that he felt had not been intruded upon, like a denial of the impinging reality, which is interesting. This may be an indication of the way Kieron deals with the uncertainty of what mummy and daddy get up to in their own bedroom i.e. He finds his own space, and acts as if nothing significant has occurred. It might also be viewed as him feeling more vulnerable, and wanting to feel safe, and deny the intruding reality.

This second session in this phase which is detailed below took place some ten months into Kieron's individual intensive therapy. I had discussed with Kieron some four weeks prior to this session about the forthcoming clinic move. There was some anxiety on behalf of the Principal Social Worker around the importance and anxiety of the move of clinic for this family especially in light of their own recent house move. Some of the family's anxiety may have somehow gotten into the thinking of the Principal Social Worker involved. Kieron is clearly not pleased with the move as demonstrated in detail below.

In this session, Kieron had not arrived on time for his 12.30 appointment. I met with the Principal Social Worker and discussed Kieron's absence for the following Tuesday – dentist appointment. I was concerned that Kieron would be missing too many sessions, especially as they were already late for their appointment today. The Principal Social Worker said she said would have a word with mum about the importance of attending regularly and explore with her if there might be the possibility of re-arranging the dentist appointment. While we were waiting for a call from reception we discussed the case in more general terms. We both felt that both Kieron and Mum were doing very well. We then focussed on the fact that mum wasn't very good at endings and tended to avoid them, and perhaps this was interfering with her ability to come regularly now that there was a planned ending. I was standing in the doorway but there was no sign of them in reception – I could only see two little girls who were with their mother.

It got to 12.45 and the Principal Social Worker kept repeating, "She's not coming is she? It's going to be such a long break before I see her again". She seemed anxious that in her forthcoming holiday absence some of the headway that both Mum and Kieron were making would be lost. I said that I had arranged to meet with Mum on the first Monday of the Principal Social Worker's absence, in the new clinic – to catch up whilst the Principal Social Worker was away. The discussion moved on to thinking about Mum's need to be the grown up in the Principal Social Worker's absence, and how she would manage without her extra support. I also thought the meeting would offer Mum the opportunity to visit the new clinic prior to Kieron's appointments so that she



would know where to bring Kieron the following day for his first appointment there, as well as forming part of a review of our work together.

I went back to my desk and a colleague said that the receptionist had been asking for me. It appeared that they had arrived 5 minutes late but had been waiting for 10 minutes in reception, but they were not visible from my standing point.

Process Session Notes (4) 13.9.07	Commentary
<p>When I got to reception and opened the door Kieron got up immediately from the toy he was playing with and turned towards me and walked through the door. His face was expressionless, and he seemed to be moving a bit like a robot. I apologised to mum saying I was sorry that they had had to wait so long, but I didn't know they had arrived. She laughed saying "it's ok, we were late anyway".</p> <p>We walked down the corridor together. Kieron was touching the sides of the walls – passing packed boxes in the corridor. He struggled with pushing the doors and I pushed them open. He started to suck in his lips and made a suction sound. I found myself copying him but without making the sound. As we were entering the room Kieron was saying, "you can't do it properly", and he repeated the sound again. I tried again and this time managed to do it. He grinned at me and seemed pleased, and I said he looked pleased that I could do it too.</p> <p>He crouched on the chair with his head buried in the back of the chair. He was silent and I waited. He stayed like that for a few minutes, and then he turned and roared and laughed immediately afterwards.</p>	<p>Comes to session easily – Kieron walking but he is not fine or ok – he depersonalises himself –walks like a robot to session and in session turns bum towards– cannot bear to be in the experience of being left to wait</p> <p>Touching walls – familiarising himself with something that will soon change and be lost – Kieron making a suction sound – trying to stick to old building? Sucking in the goodness of the breast?</p> <p>My sticking to Kieron?</p> <p>Burying his head in the sand i.e. Doesn't want to move? Annoyed about the wait - or my having his bottom. The move unsettling for him – seeing the boxes. Giving me the bottoms up! Roar to show annoyance, quickly replaced/covered up by laughter. Not</p>

He went over to the cushions and lay on the floor. He covered himself up with a few cushions and dragged a few more on top. I said that he was now completely covered up. He pushed his way out of the cushions saying, pretend I'm a worm. I say he is wriggling around like a worm. He turns over onto his back and says his willy is moving. I say that wriggling has made his willy move and he laughs. He crawls across the floor towards his chair, and I say what he is doing.

He goes under his chair saying, "I'm a caterpillar and I'm going into my shell". He lies on his side and makes movements across his body as if spinning a chrysalis around himself. I say he is tucked in under the chair and is safe within his shell. He comes out from the chair saying "I am a beautiful butterfly" and comes out stands up and waves his arms around. I say he has come out of his shell and now has turned into a butterfly - smiling. (I was thinking of stories from school about the caterpillar life cycle and also Kieron's own metamorphosis).

Suddenly he crouches down on the floor and starts to hop saying he is now a frog. I say "Kieron is showing me that he knows about different creatures today. Now he is a frog". He makes croaking noises and hops around. I say that "he is changing and that we will be changing rooms and buildings soon". I say "we have only two more sessions in this room before we change rooms". I get up and go over to his box and get out the calendar asking Kieron to come and have a look. He comes over and I point to the dates saying "this is today, and then there is our next session and that that will be our last session in this room. I say that mum cannot bring him next Tuesday so there will be a break next week when we don't see

interpreted by me, waiting to see what happens in the session first.

Covering himself with cushions – protecting himself needing 'padding' from the harshness of the move– play progresses

Worm/willy getting itself inside somewhere. Kieron wanting to bury himself in the comfort of the room. Excitable/arousing play

Game continues with butterfly play – something emerging – story book from school?

Something changing/transforming  
Kieron under layers – he wants to get away – worm his way into the building. Inside him - emergence as a butterfly – he has a sense that something about him is emerging – changing buildings, something different. he is beautiful and lights up my eyes – so important

The frog prince story? Frog to a prince. Another transformation tale

I am thinking about the ending with Kieron

Trying to make it as clear as possible to avoid the not knowing surrounding the move to a new clinic and therapy room.

each other". Kieron is nodding but I feel that he doesn't quite understand.

I say "would you like me to draw a picture of the new building?" Kieron says "yes". I take out a piece of paper and draw the building we are in saying "this is where you and your mum come now". I draw stick people for Kieron and his mum. Kieron says "is that me?" and I say "yes", and then he says "is that my mum?" And I says "yes". He is smiling and then says "where's my dad?" He picks up the pen and draws two small round shapes saying "there he is". I say that he has drawn two small shapes for his dad, and he says it's his pockets. I help make the pockets into another figure for dad (squiggles Winnicott). He laughs saying "he looks big now" and I agree he that he does. I say "I will draw the new building now" and Kieron watches as I draw what I know of the new building. I say "I haven't seen inside the new building but I know that there is only a downstairs and an upstairs and that the windows have green frames". I draw the frames in green and the door too, explaining that this is what the new building will look like. I say "the building is different and we are meeting in a new room, but everything else will be the same". Kieron looks interested. I say "I will take your box and add "there will a window in the new room". "How about them?" he says pointing to the teddy and hedgehog puppets. I say "I shall take them too". "Will I see someone else?" I say "I feel that Kieron is a little anxious that Davina won't be there, would you like to see someone else I ask?" "Yes" he says, then grins and says "only joking".

Kieron starts to hop around the floor – he has two arms on the floor and one leg in the air. I say "I wonder if Kieron

I can absorb that it is confusing for Kieron. A loving act - drawing a picture of the new building - from me that Kieron can respond to. Kieron is very responsive when I get the right level

Wants dad to be there too - inclusion – his family coming together to help bring him/support him with this change

Two pockets – dad does have capacities. Perhaps a dual aspect to dad? Things hidden? Possibly a containing function?

"How about them?" I contain his anxiety – he can ask questions now – you can't ask questions when you are anxious. Impressive just how much he is changing

Kieron very attached to me and senses my attachment to him. He doesn't want anyone else, can even make a joke and laugh about it

is a little unsettled about the move? You are hopping around and really don't know what the new place will be like". He hits his head. He starts to cry and says "I want my mum". He told me to go away when I offered to put a wet towel on his head. He repeated that he wanted mum – there were no tears. I say "I can hear that he is hurting but I notice there are no tears". I say "Kieron is very upset about the move, and wants to suddenly be somewhere else". Kieron sits up and says with his eyes closed, "can you find my eyes?" I say "it is very difficult for Kieron to think about a new place that he hasn't seen before, perhaps he feels as if he can't see what it will be like and is a little afraid". Kieron said "you close your eyes too", which I did, saying "Davina hasn't seen inside the new building either, so both of us are a little anxious about what it will be like". I say "let's pretend that we are in the new building". Kieron goes to the door and knocks. I move cushions so that he is behind the cushions. I say "Kieron has knocked and entered the new building now, and Davina is coming to reception to take Kieron to the new room". Kieron is smiling. I take Kieron's hand and say "we are now walking down the corridor" and then pretend to open a door to the new room. We walk in and I say, "over there is a window, and look there is the table, chairs, and your box". Kieron says, "there is the teddy and hedgehog, hello, I'm here". I look at the clock "it is almost time for us to stop for today".

Kieron helps me to pick up the toys and we walk down the corridor together. As we pass the Principal Social Worker's room I knock. Mum comes out with the Principal Social Worker and Dad who scoops up Kieron and gives him a big hug. Mum

'Hitting his head' – feels unsettled about the move – "Davina you are doing my head in!" Too much reality? painful

We are thinking together and things are being discovered, and Kieron is blossoming.

I make it an experience that he can relate to and enjoy – this is received by Kieron as a constructive demonstration rather than interference.

He demonstrates his confidence that he will be able to feel at home in the new room "hello, I'm here" Melanie Klein – Richard – island that comes to life – ahoy there – he had a dead internal world, now Kieron has an expectation that someone will respond. He can project himself into the future situation that he will exist in a new room and that he is thought about. Depressive position – butterfly

There is an 'at oneness' and a feeling that we are in it together – Kieron exists in my mind, and I am more in Kieron's mind

Kieron is like a young toddler – he is immature in terms of developmental experience. Joins in the game and adds to it

Davina making scary, unknown situation more tolerable for Kieron

says "I will bring him next Tuesday, I will get someone to bring him, and we don't both have to go to the dentist ok". I say "that would be good, as it will be our last session before the move". I confirm that we will be meeting whilst the Principal Social Worker is away. The Principal Social Worker hands mum a list of dates to bring Kieron and dates of when she is back.	
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#### **Discussion (4)**

This session shows not only Kieron's ability to adapt to change but also his new found ability of containing his anxieties aroused by the change of building and room. Somehow the external changes seem to be linked in his mind to a sense of inner transformation. There is a strong sense of something good and positive emerging both actually and internally. Kieron's capacity to ask questions and make jokes is indicative of the close relationship he has formed with me. Despite the feeling of anxiety Kieron can hear that although some things will be changing his good external (and now internalised) object will remain consistent. Kieron has had a very satisfying experience in the room and trusts me enough to be able to rely on my continued presence. The magnitude of this cannot be overlooked; Kieron home life is very chaotic, with few boundaries and even fewer certainties, that he has been able to master this idea of change at all and hang on to it is incredible.

The developing sense of Kieron as being part of a triangular relationship is also important to note here. Kieron's obvious delight at being drawn with his Mum by me was even more noticeable when he wanted to include his Dad too. Kieron is showing that he has a much clearer idea of who he is in relation to his family i.e. he is the 5 year old boy and he has two parents who are in a relationship together. This links in to the concept of Kieron being the small one in his caterpillar/butterfly and tadpole/frog play. The idea that it is ok to be small and have an idea of developing and growing up is fascinating here, especially if this is viewed in the sense of changing buildings and rooms. Kieron may have the phantasy that the move represents a growing up in some sense; at the very least the move may mean that he is moving on to something bigger.

Kieron shows that his agitation and anxiety can be contained and thought about in a meaningful way. He can project himself via his imagination into the new setting and feel assured that his familiar playthings will be there. With this assurance his internal transformation has begun, a new chapter in Kieron's life takes shape and is welcomed. Feelings of being out of control or unmanageable have retreated being replaced by those of hope and joy.

These three phases show the gradual development and progression of a somewhat psychopathic natured boy who moves towards a more healthy way of interacting with life. His interaction moved from a sporadic, almost meaningless frenzied activity, to purposeful, thoughtful, imaginative play. Kieron's capacity to contain his anxiety in the room is remarkable. He became quite simply a delight to be with, and a real depth of feeling developed between us. This is imperative for any real change to occur – to see oneself reflected in the eyes of another in a positive, loving way (Reid, 1990). This idea of being reflected in the face of another has previously been written about by Winnicott where he states that:

*"In emotional development the precursor of the mirror is the mother's face" (Winnicott, 1971)*

Whereby, the mother's role of giving back to the baby the baby's own sense of self is of vital importance for its development.

Sandor Ferenczi (Ferenczi, 1926) wrote that it is the analyst's love that heals the patient, or maybe as Robert Caper suggests (Caper, 1999) it the analysts love for analysis, and the capacity for the patient to work through the experience of having a third person in the room in the form of the analyst's mind being the third person that helps the patient. The resonance between Kieron and me is clear, I am able to think and be helpful to Kieron. This is particularly noticeable in this session when I outline what the new clinic will be like, and Kieron joins in quite easily with his comment, "there is the teddy and hedgehog, hello, I'm here". He is able to join me in our imaginary walk and adds to the scene. Kieron is able to internalise me as a good helpful object and has created a positive transference - free from negative projections - that he has been able to use for his own benefit. The butterfly, the image of transformation, is used by Kieron in this session, and what a powerful image it is. It demonstrates his own

transformation that I had witnessed in the therapy room during our work together, but on an unconscious level it could be seen to indicate Kieron's own acknowledgement of both his internal and external change. I am sure Kieron is not conscious of the same representation that the butterfly symbolises for an adult, but in his own little way, he is aware that something is going to be different – the clinic - and that he is very different – his behaviour both in and out of the therapy room.

It must also be mentioned of course, that I do not consider the improvement in Kieron's behaviour to be simply a production of my therapeutic input. I had regular, excellent supervision from a consultant child psychotherapist with many years experience in the profession and especially with children with ADHD, plus there was ongoing work with the Principal Social Worker with mum and sometimes dad. Research (Lush, et al 1991) indicates that the best outcome results for psychotherapy are when parents also held by another professional. It does of course take time to build relationships but the results are very encouraging and demonstrate clear improvement. It seems to me to be essential to free up the mother's mind to allow a developing space for her son to develop in his own right, free from her otherwise harmful, hostile projections.

#### **Phase 4 – After the First Year of Intensive Psychotherapy**

Although I have focussed my attention on the first year of treatment for the purpose of this thesis to demonstrate what change is possible through psychotherapy over this period of time, it is I feel necessary to mention that I did continue to see Kieron for a further twelve months on a three times weekly basis. These took place in the new clinic.

There were many external changes that took place during this time in Kieron's life. The most significant of these for Kieron was the breakup of his parents' marriage. One New Year's Eve during this time, Big Kieron was arrested for assaulting two minors during a street brawl whilst drunk from the New Year celebrations – one of whom suffered a serious injury; he had his throat cut. Due to the fact that Big Kieron's assault was on minors, Social Services became involved instantly, and Big Kieron was refused access to his family. This coupled with Big Kieron's affair with a neighbour, Tracey, prompted Viviane to decide to proceed with their divorce. Tracey also had four children, one of whom was in Kieron's class. Although Social Services had insisted that Big Kieron could not live with Tracey due to his arrest, Big Kieron chose to ignore this restriction. Big Kieron was living very close to his family's home but with a different family. This was particularly difficult for Kieron to manage; he failed to understand why his dad had moved out, but perhaps even more confusing was why he was living with another family, the children of which went to his school. He came to sessions distraught, angry and confused.

There were several incidents of criminal damage suffered by Kieron's family, and unfortunately witnessed by Kieron. One of these incidents involved Tracey's eldest son who put a brick through Viviane's car windscreen which was parked on her drive. Kieron's sudden separation from his dad was even more traumatic because there was no access arranged for Kieron, even though it was repeatedly promised by Social Services that this would be occurring. During this time Big Kieron sought help from local adult services, but contact between him and Kieron was never arranged as agreed. Viviane reported ugly scenes at the family home, with Big Kieron turning up drunk, throwing bricks at the door being abusive and shouting threats to burn the house down whilst the



family were inside. The police were informed and the house was fitted with an emergency panic button which was linked to the local police station. Viviane turned up for her sessions with the Principal Social Worker dishevelled, stressed, and angry but also resolute not to continue her relationship with Big Kieron any further. In Kieron's sessions he spoke of his parents being back together, and of Dad still being at home. It was difficult for the Principal Social Worker and I to ascertain whether this was pure fantasy or reality at times with such conflicting, and opposing stories.

Below are the process session notes that took place some months after Big Kieron left the family home. Mum had not brought Kieron the previous Tuesday, and Dad had left a phone message at the clinic to say Kieron was 'throwing up'. This was surprising and a little tricky to manage for the Principal Social Worker as Dad was not allowed contact with the family. Prior to the session the Principal Social Worker discussed with me about confronting Mum about the phone message we had received from Dad. She stated that she was a little apprehensive about doing this as she didn't want Mum to think she was trying to catch her out. I felt that it was the Principal Social Worker's countertransference that was blocking her work with Mum and prevented her from confronting Mum with the dilemma of whether to notify the Police and Social Care.

In this session Kieron clearly demonstrates the full impact of his vulnerability and sadness. He had "supposedly" not seen his father for around five months, and is shown below to be thoughtful and able to reflect on his own feelings even though they are painful and difficult for him. This is a major shift from where he was when he first came to the clinic:

<b>Process Session Notes (5) 29.5.08</b>	<b>Commentary</b>
When I went to reception Mum was there with Jake, Bethany and Kieron. Kieron got up to come to the room and was holding a large coach car. Mum said that Kieron was a little better than yesterday, that they had all had it, and that Kieron still had a 'runny tummy'. I said "hello" to Kieron and said "you	

need to leave the coach with mum". "It's mine" he said "and it's new". I said "it looks like a very nice coach" and Kieron said "I got it at Caister". We were just in the reception doorway and I said again "it needs to be left in reception with mum" and Kieron said, "no!" Mum called out "give it here Kieron", "No!" said Kieron. He walked back towards mum and sat next to her. Mum said "I'll look after it for you". "No!" said Kieron in a really loud voice. 'Calm down' said mum. 'I WANT TO GO HOME' shouted Kieron. Mum said simply, "you can't. I'll keep it then" she added. "NO!" said Kieron shouting even louder. I said "Kieron is upset about not being able to take things into the room, and I remember that there was something about this a little while ago about wanting to take something of his into the room, but that Kieron knew that there was a rule about taking things into the room". "I won't break it" he said. I replied "maybe that is true, but that Kieron knows the rules". I say "Kieron isn't feeling very well still, and I can understand why he might want to bring something familiar in, but that I don't think it is a good idea". I added that "I think that Kieron wants things to be exactly how he wants them to be". Mum nods saying "he's been like that all week". I say "let's ask mum to walk you to the room shall we?" I get up saying "let's go". Mum, Kieron and I walk to the room, mum comes into the room and tries to go and Kieron clings on to her arm. Mum looks exhausted. She says again "he's been like this all week". Kieron sits in the chair and mum removes his hand from her arm. Kieron says "I've got the cards", mum says "no they're in the car" and Kieron says "no they are here". He reaches behind himself and pulls out a small blue package. Mum says "leave those in your pocket", and Kieron puts them back (I am uncomfortable as I feel that

Idea that something important is being taken away from him, and desperation about hanging on to the coach – which he got from Dad

Importance of me being straightforward with Kieron and with this family – something different from what he is used to

What has happened to make him so clingy? Is it simply about being unwell and needing his mum to be near? Little thought appears to have been given by mum as to why, but a noticing that his behaviour has changed somewhat

He has managed to slip something by mum, but he has left the coach in reception. Sense that Kieron has gotten round the rules somehow, and that there are things going on behind Davina's back? What else is being hidden?? Difficult to really know what

<p>although he has sneaked them in, he has made it common knowledge at the same time, I also didn't want to get into another confrontation with Kieron on the back of the last one!).</p> <p>Mum leaves and Kieron gets up and goes over to his box. He has his back to me and says, "do you know where I've been?" I say "you want me to guess", and Kieron says, "you have to guess". I say "Caister", and Kieron nods. He has taken the lid off his box and is looking at the calendar and says "what are all these big X's?" I say that "the X's are the summer holidays when Davina won't be here, and that is also when Kieron is off from school on holiday". Kieron "guess where else I've been". I say that "Kieron wants me to guess again". Kieron nods and I say, "Yarmouth" (where he has told me in a previous session that this is where dad lives). Kieron looks at me and says "you're good" smiling approvingly. Kieron says "dad looked after me". I say "dad looked after you in Yarmouth?" Kieron says "yes". I ask if dad has a bed for Kieron there, and Kieron says "yes". (I am not sure whether this is pure fabrication, wish fulfilment or a reality). I say "I wonder what it was like seeing dad?" "He was fine" said Kieron. I say "it's been a long time since you have seen dad" and Kieron says "no it's not! I've been seeing him for two weeks!" (I don't know what to believe at this stage, and wonder if it's mum or Kieron that is not being honest with us at the clinic about dad).</p> <p>Kieron gets out the pen and scribbles briefly on the side of the box then gets out his folder with his paper in. He gets is out a pink sheet and starts to scribble on the back. It is a black dense blob. He then draws a spiral. "look at this" he says. I say "I wonder what it is?" and Kieron says "it's a</p>	<p>is really going on in this family? Lost the battle re the coach, but won the battle with the cards. Can allow mum to leave – sense of triumph for Kieron</p> <p>Guessing game</p> <p>X's -Kiss of death? Mean absence, so something painful, not something loving</p> <p>Kieron notices how attentive I am - he is pleased</p> <p>Listening to Kieron I have a sense that I too am confused. Also, I am aware of the distinct possibility that he may have seen dad, but had been told not to tell anyone. I am inclined to believe Kieron's version of events.</p> <p>This is Kieron's first <u>real</u> picture – which is just wonderful to witness and be part of – a real achievement for this boy.</p> <p>Snail's have a hard exterior, soft</p>
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snail". He adds the head. He looks very pleased (It's the first real drawing he has done). Kieron draws the horns and says these are his eyes. (I am impressed). He gets out another piece of pink paper and starts to draw another one saying "this is the kid". He draws another snail. "I'm going to take this home" he says. I say that "these drawings must stay in the room, but at the end of the session I will photocopy them and he can take the copies home with him". I say "he wants to take something away from the session to hang on to, and maybe this is because his sessions have been a little irregular due to him being ill and mum being ill last week". Kieron says he wants to stick them on the wall. He looks in his box for the sellotape. I say he can stick them on the cupboard (the sellotape takes off the top layer of paint from the wall). Kieron announces that he can do sellotape now. I say "Kieron is letting me know that he can do more grown up things and that he doesn't need me to cut the sellotape any longer". He has the sellotape in his mouth and is biting it with his teeth. He manages to stick the two pictures on the cupboard. He then draws two more snails on pink and one on yellow paper. They are smaller and smaller in size. He pauses to look at them and says "they are really cute". I say "I wonder if Kieron feels a little bit like a snail today?" I add that "they have a tough shell, but inside they are very soft and can be easily hurt, and I add that Kieron hasn't been very well lately, and still isn't completely better".(thinking of Kieron's runny tummy). Kieron is busy drawing happy faces on the snails. One doesn't have a face and Kieron says "this one isn't happy he's sad, he's the kid". I say "I wonder why the kid is sad", and Kieron says "he misses dad". I say that "the kid misses his dad, and that Kieron is

interior. Slow moving – unlike Kieron when he first started therapy! There is a much slower pace in the room, which leaves more room for thought and reflection. The softer side of a snail is exposed and then retracted, which seems to represent Kieron's vulnerability being brought into the room, and perhaps hidden inside his tougher exterior outside the clinic.

Pictures displayed – Kieron wants his vulnerable side to be visible as well as his tough exterior. This creative burst is an aspect of Kieron that he can be pleased. By displaying his achievements his satisfaction is evident, it might also be seen as him marking his territory. He is displaying his strength and weakness simultaneously

He draws attention to the kid, and the kid's sadness, which is himself. He is very sad indeed

Kieron's tolerance for emotional pain is much greater now, he can express his sadness much more easily, without acting out behaviourally

<p>letting Davina know that Kieron really misses his dad too". Kieron nods silently.</p> <p>"My mum and dad aren't back together" he says flatly. I say "mum has told Kieron that they won't be getting back together?" "I know" says Kieron. He looks sad and I say "it is really hard for Kieron to be very small and not be able to change the things he would like to change, like making his mum and dad get back together". Kieron sticks up the rest of his pictures. On the cupboard and asks me to help hold the pieces in place. I feel he is very vulnerable and would like to retreat inside his own snail shell. He looks at the sellotape and says I know let's make one of those sellotape balls. I say he is remembering making one once before. Instead he fixes the end to the table and walks to the end of the room loosening the sellotape in a long stretch. He sticks it to the blanket on the couch. I say "Kieron has divided up the room with the sellotape". "Yes" he says "this side is the chair side and this side is the door side". I say "I am on the door side and you are on the chair side". He comes underneath the tape to my side. I say "Kieron is on the same side as me now".</p> <p>Kieron says that he wants to be a builder; he says he wants to build a tunnel. He looks through the box and wants the long lego pieces to build it up. I say he is keen to get it built. When it is finished he gets the police van and pokes it through the tunnel – it comes out on the other side of the tape. Kieron says that the police took his dad's clothes. I say "I wonder why they did that" (I am thinking of forensic evidence!). Kieron says he doesn't know, I say "maybe it's a little confusing to think about why the police are taking dad's clothes, it's not something that they would usually do".</p>	<p>Kieron hears Davina's question as a repetition of what he has already heard from mum. Perhaps this is a little insensitive of me as it confirms what mum has said and possibly thereby compounds it in his mind – this may be experienced as an assault by Kieron</p> <p>A sticky ball, Kieron wants to stick to something, remembers a happier time in his sessions</p> <p>Split in family replicated in the room</p> <p>By moving to my side of the room Kieron shows that he wants to identify with me and with the clinic, and is putting things together – which is very important step for him to make</p> <p>Kieron wants to be a builder – he has a very reparative side that does want to create and build. This has been strengthened by his experience of his therapy - working through his negative destructive impulses and realising that good things can be built in spite of differences and difficulties. This demonstrates Kieron's gratitude of what is being offered in his therapy and just how much he can accept and take in the positive interaction</p> <p>The tunnel is another structure with a shell, a shell that is protecting something that is 'going through it'. Kieron is going through it emotionally at the moment.</p>
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<p>Kieron is adding lego in front of the tunnel, and he says it is so the van knows which way to go in, and then he does the same at the other end saying the van knows which side to come out. I say "I think that Kieron is showing me that sometimes when mum isn't well and he isn't well that it gets confusing about when he comes here and when he doesn't". Kieron continues to poke the van through.</p> <p>I say "I wonder if Kieron would like a tunnel from his house to the clinic, and one from his dad's to the clinic?" "And one from mum to dad's" he says. "yes", I say "and then Kieron would be able to decide where he wanted to go, without having things confused – it would be a lot easier just to pop through a tunnel and turn up at dad's or at the clinic just when he wanted"</p> <p>Kieron looks up at the clock and says "it's almost time to stop and we need to clear up", I say "you are right, there are only a few minutes left today, but that we will be meeting again tomorrow". We both get up and start to clear up the room together and I comment on what we are doing together.</p> <p>When we are finished I say that I will photocopy his drawings, and Kieron says and this (the tunnel). I say that I can only photograph his drawings as they are flat. "I want to show mum all my hard work I've done" he says. We go to reception and I say to mum "We have finished but I have told Kieron that I will photocopy his drawings to take home, would you be able to wait just a couple of minutes longer?" she smiles and says "yes".</p> <p>I go to the photocopier and make a copy of each of his drawings (five in total) and return to reception to give</p>	<p>Kieron is using the tunnel to try to make sense of something very difficult. How does Kieron make sense of the coming and going to therapy, and the coming and going to his dad's?</p> <p>Kieron able to use the idea of a real tunnel between places that I suggest and he adds that he would like one between his parents' homes too! We are attuned to each other here. Kieron appears to be using the therapy to orient himself. He leaves the session on the side of working things out, and not just the confusion that he came into the room with at the beginning of the session</p> <p>Kieron taking control of the ending of session – elsewhere he is unable to have any influence on his external environment. Kieron uses phrases that I have said in previous sessions demonstrating that he has internalised 'how we do things at the clinic'</p> <p>Kieron's comments show his own sense of achievement that he would like to be acknowledged by his mum.</p> <p>Something being snuck in at the end –</p>
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<p>them to Kieron. Kieron says “look at my work” and announces that “they are snails”. Mum, Jake and Bethany are all smiling and looking interested as Kieron lays out his pictures on the sofas in the reception area. “Cool” says mum. I say “I’ll see you tomorrow”, mum says “will it be ok if we don’t come tomorrow” she says, “we are all still unwell, and I’m exhausted”. (She looks it). I feel on the spot and find myself unable to say no you must bring him tomorrow. Instead I say to Kieron “Mum is still not feeling well and so we won’t be able to meet tomorrow now, and that I will see him again next Tuesday”. Kieron is looking at his pictures and doesn’t seem to be listening.</p> <p>Mum says “listen to Davina”, and Kieron looks at me. I repeat “We cannot meet tomorrow as mum is still not well and that I will see him next Tuesday”. He says “Bye”, and I’m left not sure if anything has registered about our cancelled meeting at all. I say “Bye, see you on Tuesday”. They all say “Goodbye” and I leave them and return to the room unsettled.</p>	<p>like the beginning of the session.</p> <p>In the session Kieron internalises my ideas, time, patterns about when he come and when he doesn’t, how he comes in and goes out, he feels the integration of male and female, but this quickly gets dismantled when he leaves the session – he tunes out and does not listen. Back to the confusion of his chaotic home life. I am left with Kieron’s sense of being unsettled</p>
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### Discussion (5)

The confusion and underhandedness that Kieron experiences externally is unfortunately replicated in the therapy detailed above. The trickiness that the Principal Social Worker experienced in confronting Viviane about the phone call from dad, my not taking up the things that Kieron had sneaked into the session, and the devious way it is left to the end of the session to tell me that Viviane cannot bring Kieron the following day are all evidence for this. It is something that I struggled with throughout the therapy and although I tried repeatedly to offer a sense of continuity, boundaries and containment this was often unconsciously undermined and sabotaged by Viviane. These attacks on the therapy usually occurred directly following on from the end of a session, which was very frustrating indeed. Usually in the session with Kieron our next

meetings were discussed, and Kieron appeared to have a sense of what was happening, then this understanding became undermined and proven to be 'untrue' when confronted by Mum's altercations outside the session prior to him leaving the clinic. Although I do not feel that there was any malicious intent on Viviane's part, it was quite difficult to maintain consistency in the face of such regular change, disruption and external chaos. For Kieron and his family this was 'normal', and my regularity of contact and firmness of boundaries although consciously longed for, were unconsciously regularly attacked.

In the sessions Kieron shows a clear understanding of what I am trying to think with him about. His additional comment about having a tunnel between his Mum and Dad's house are clear proof of this. There is a real sense that he is trying to link all of us together in some way both in a physical way by means of the tunnel, but also mentally and emotionally in an attempt to make his life less complicated and more predictable. It was very moving to be present to watch this young boy really trying to work things out, especially as he was able to articulate so well his loss, sadness and confusion.

The images that Kieron chooses to draw are also fascinating here. As mentioned these were his first ever real drawings, and they were of a creature that moves incredibly slowly – the opposite of how Kieron was when he first came to therapy! Snails do have eyes that are on long stalks, and writing this now, it reminds me of the very first time I met with Kieron, and how he liked the giraffes that similarly have long necks and are able to see around. The major difference is that giraffes can move incredibly fast, and snails, most certainly do not. Snails have a very thin shell, and I think there is a strong element of this around Kieron now i.e. he has a protective shell, but it is also thin, and maybe not so resilient to the blows that his life had dealt him recently. The old Kieron would have shrugged off the disruptions and acted out accordingly. The new Kieron is much more aware of his vulnerability, and able to verbalise this in session. Kieron feels and acknowledges the pain of his situation but also much better equipped emotionally for dealing with it both internally and externally.

I will now look at the remaining time that I met with Kieron but in far less detail (this is not because it is not important, but rather that for the purpose of this



thesis I am, as mentioned, concentrating on only the first year of therapy in depth). I have chosen two snapshots of the work that was carried out over the next eighteen months. I saw Kieron twice weekly for one term, with a reduction to once weekly in the following term. Kieron's reactions to these reductions and gradual phasing out of therapy were enlightening to say the least.

After having met with Kieron for two years three times per week, I arranged a meeting to discuss with Mum a reduction from three to two sessions per week for one term, and then once weekly for the following term with an ending at Easter, she seemed content and happy with the reduction, mentioning her concern about Kieron missing out on school. When I broached this subject with Kieron however, his response to the reduction in our meetings from three times to twice weekly was, *"that's a bit harsh"*. I was taken aback – as I so often was – by his grasp and understanding of what the implications would be for him, and how he had managed to convert this knowledge into words that he expressed so succinctly yet quite simply.

The introduction of reduced sessions, although discussed and agreed with Mum, proved quite challenging to maintain. Kieron's sister developed a tooth abscess and Mum had to cancel several appointments due to hospital visits which conflicted with Kieron's appointment times. Kieron was also quite poorly first with a flu and then a sickness bug, which made sustaining our twice weekly contact quite difficult. On occasions I felt I had to offer alternative day and times in order to preserve Kieron's already diminishing space and to help him maintain the idea of consistency and reliability in his mind. His play during this term was filled with building safe places, and his taking things away from me, which I interpreted as his frustration of not being able to control his sessions which he saw as me taking away something from him – his food – and a loss of his own safe space.

*"I know" he said on entering the room, "I want to play that dog game again". (He had spent the last few sessions building a kennel from the large chairs and cushions in the room). "What's my name?" he asked. I said "I think that Kieron was testing Davina to see if she could remember what Kieron had called the dog last time we played. Did I remember*

Kieron". He grinned. I said "Psychic"; "Correct" he said getting down on all fours. "Can you build it please?" He asked. I said I would move the chairs but he could help with the cushions. We built the kennel together. "Is that the same space? It looks smaller" he said. I said "it is the same space, but maybe it feels to Kieron like it is smaller. Perhaps it has something to do with our meeting less times now, and how difficult that has been lately, because of illness and Mum being unable to bring him as regularly, it feels to you like you have a smaller space here". I add that "in a few weeks we will only be meeting once a week". Kieron stops what he is doing (arranging the blanket for the kennel roof) and looks me straight in the eyes and says, "That is very sad" then a pause, and "I will miss you". I felt stunned and suddenly very sad indeed, and quickly said that I would miss Kieron too. I said "although we wouldn't be meeting as often as we had, Kieron would always have memories of coming to the clinic and coming to see Davina". He nods, and disappears under the blanket, and into the kennel. "Its night time now" he says, "can you turn off the light". I say that "Kieron feels very sad, and wants to hide in the kennel, and it suddenly feels very dark in here. It's hard to think about not meeting so often, and it makes Kieron feel like he wants to hide".

Kieron pops his head out and says "can you draw a bone? I will cut it out" he says. I draw a simple bone and Kieron smiles, he draws a bone too saying, I did this myself. I say he wants Davina to know that he can manage to do things by himself, as well as sometimes needing to ask for help. He takes his time cutting out the bone (he chooses to cut out mine). I say "Kieron is being very careful with his cutting out, and that he is trying very hard to keep on the lines". "Yes, I can cut this out". I say that "this is something else that he is showing Davina that he can do", I add that "I remember when Kieron first came to see Davina that he couldn't cut out nearly so well". Kieron is smiling. I continue to say, "I think you are showing me that you will be able to cope on your own when we are not meeting so often". "You leave the bone there and you don't see when I take it" I pretended to be surprised when the dog took the bone and said, "oh dear, what has happened to my bone! That bone was

*for Psychic, and now it has vanished". Kieron starts to bark, and comes into view with the bone. I say that "I feel that Kieron is letting Davina know how surprised he is to hear that his sessions are going to be reduced to once weekly in a few weeks". "Do it again", he says. We repeat the game for a few more times before it is time to clear up. I feel like the thieving dog that sneaks Kieron's sessions away when Kieron isn't looking.*

The toleration of absences that Kieron had demonstrated filled me with hope. He had been able to bear my absence due to my personal illness earlier in the year, and now he was able to show that he understood what a reduction of sessions would feel like for him and to communicate these very touchingly. I thought again of Bick's paper, where she says:

*"Only an analysis which perseveres to thorough working through of the primal dependence on the maternal object can strengthen the underlying fragility". (Bick, 1968).*

What insight, what an amazing boy, I thought, and how internally strong he has become, not just pseudo-maturity, but a real acknowledgement of the importance of his sessions, his reliance and dependency plus the beginning of a recognition of his forthcoming loss and how that might feel and be managed.

The reduction down to once weekly sessions was again shrouded in misunderstanding and confusion. I had discussed with Mum – in two review sessions the previous term – how this would happen but somehow at the commencement of the final term of therapy she missed the first session back, explaining her absence with *"oh, I thought he had another session on Thursday"*. The Principal Social Worker and I discussed Mum's anxieties and denial about the forthcoming ending, and this was taken up in Mum's individual sessions. This absence had made the Christmas break an even longer than expected (four weeks). It seemed that Kieron needed to let me know just how long it had seemed for him by his opening comment to me on leaving the waiting room of "I'm still six". I responded by saying "it's not that long since I last saw you, you haven't had another birthday during the long break, but perhaps it feels like a really long time". Kieron used the session to

spontaneously revisit past sessions – particularly the ones where he had played certain games after the break. I had heard about thinking with patients about their sessions and where they were at the beginning of therapy and where they were now etc, but somehow Kieron seemed to be bringing these into the room instinctively. I remember thinking to myself that he –at least – had the idea in his mind about having a break and what that felt like, even if Mum hadn't quite got a handle on it.

Kieron's play was quite angry during this final term, and this was directed towards me as the one who he saw was in charge and the person who was taking away his time:

*He jumps up and goes over to his box and takes out the police car and little red car. He says that he is the policeman and I am the little red car. I watch as he plays chase. I ask "why is the red car being chased today?", and he says "he's broken the law; he's driving without a licence". He pushes the car up towards the couch and heads it off with the police car. "You are going to prison" he says. I say "the red car has done something very wrong and now has to go to prison. I say that Kieron is very angry with Davina for ending his sessions and he feels that she has broken a law and should be sent to prison." "Yes, locked up" he said. I say "it is very painful to think about ending here and having no more sessions, and that what Kieron would really like is to lock himself in here with Davina and not have to face thinking about not coming here again". Kieron says to the red car, "Where are you going? Where are you going?" I say "I think Kieron has lots of questions about where Davina is going, and what it is going to be like when he isn't coming here any longer". Kieron looks quite sad. "You have to go to prison" he insists. I say "you feel that Davina should be punished and that you are very anxious about whom I will be seeing when you are not here, and who I might be with". Kieron says "you need to go to prison... and your husband", he adds.*

*I say "me and my husband need to be taken away and put in prison, because it feels as if we are hurting him and that should be against the law".*

*"When do we end?" Kieron asks. I decide to take this up with Kieron by speaking about his anxiety about when his sessions will be finishing with Davina, and how much time we still have together. Kieron asks "can I hold the clock?" I say "Kieron is very angry with Davina about having to end, and Kieron would like to be the one who can hold the clock and be in charge of when we finish, not Davina". "Yeh", he says resignedly.*

Mum had requested a meeting with me because of Kieron's anxiety about ending his therapy. I met with Mum and we discussed Mum's anxieties about the forthcoming ending as well as Kieron's. I reassured her that both she and Kieron would not be forgotten, and that the Principal Social Worker still had plans to continue meeting with her on a regular basis. After Mum felt contained she delightedly told me how well Kieron was continuing to do at school. She spoke of her recent relief when he had come home one day from school to say that he had been hit by another child and that he hadn't retaliated. Mum had asked him why, and he said *"because I would get into trouble"*. For Mum this was a positive indication that he was able to behave in a way that his father still could not. Kieron had demonstrated quite clearly that he could think about consequences and could choose not to react.

### **Recent Developments**

In more recent months since Kieron's therapy has ceased and I have left the clinic where I trained to take up full time employment as a Child and Adolescent Psychotherapist, there was a period of around six months during which mum did not engage with the Principal Social Worker at all, despite letters and phone messages being left to encourage mum to continue to meet. Amazingly, it was Kieron who persuaded his mum to return to the clinic. My phantasy is that he wanted to continue to meet with me or at least to have a glimpse of me at the clinic. This may be a projection of course, as I often find myself wondering how

he is doing – not least because I am continuing to write up my thesis. Kieron had a huge impact on me, and I would like to imagine that this was reciprocal.

During a meeting with the Principal Social Worker, Viviane and Kieron, Kieron disclosed that his Dad had hit his mum. At first, Viviane denied this to the Principal Social Worker, but then when Kieron insisted again, she retracted and confessed. Viviane was described as feeling ashamed and hopeless in her ability to regulate her relationship with Big Kieron. The Principal Social Worker discussed with me how she felt that Kieron had brought his mum for help, demonstrating that he knew the clinic was a place that was helpful and that he had retained the idea of a helpful internal object somewhere.

Following on from this disclosure, Viviane had again split from Big Kieron, and was offered some short term individual therapy (CAT – Cognitive, Analytic Therapy), which she accepted and thoroughly engaged. Viviane reported that Kieron continued to be unmanageable at times and she has recently taken Kieron to be assessed for ADHD by the clinic psychiatrist again. The psychiatrist has acknowledged that Kieron does have some symptoms, and described him as being 'borderline' i.e. the psychiatrist is not convinced of Kieron's diagnosis as he does not meet the criteria. Thankfully to date, Kieron remains undiagnosed and not medicated.

## Findings

What I have aimed to demonstrate in this thesis is that being able to offer intensive regular psychotherapy with a very disturbed, deprived young boy can prove to be extremely beneficial both psychologically and emotionally. Also, it can hopefully provide an alternative positive intervention to that of long term medication, diagnosis and long term labelling.

The first three phases show, I feel, a clear movement away from the uncontrollable, unmanageable, psychopathic young boy in phase one, to a boy who begins to trust, at times, in an “external mummy” who can think about him and try to keep him safe in phase two, and then on to a much healthier young boy who is able to relate in a thoughtful, imaginative way and who can develop the capacity to be appropriately inquisitive in phase three.

In phase one, it was evident in the room that Kieron’s internal support or coping mechanism had developed in a distorted way with a fear of falling apart quite possibly being the unconscious motive for his chaotic behaviour. This I believe would be in response to Mum’s unconscious communication of distance, through her depression and self absorption at the beginning of Kieron’s early life. Bion (Bion, 1967) speaks of movement as being an unconscious option when a young child is faced with feelings of nameless dread and annihilation. There seemed for Kieron to be a blurring between the boundaries of body and mind and his violent act (hitting Davina in the face) might reasonably be seen as a mechanism for Kieron to rid himself of an intolerable state of mind (Perelberg, 1999). Kieron’s defence system seems to have evolved from trying to have some sort of impact on an unavailable mother, which seems to have fed Kieron’s omnipotent phantasies of invincibility.

In phase two, Kieron is seen to be struggling – as was Davina – with containment in the room. The sense of Kieron having another being present and offering a safe place in which to feel contained seems to have been a very alien type of experience for him. For Davina having to be that person in the face of very challenging behaviour was quite difficult. There is a strong notion of both therapist and patient being in this difficult position together. I can recall

the feeling of having to be very aware of what I was saying, and constantly monitoring whether Kieron had somehow managed to slip something by me, in a sneaky manner. My attention had to be one hundred per cent, and if I lapsed, even a little, it seemed that Kieron would get the better of me. This was exhausting, but certainly provided lively, interactive material for analysis. What seemed to happen during this phase was that Kieron developed a gradual trust in the fact that although we were only together a few times per week, our meetings were consistent, that there was continuity and that we would be reunited soon.

In the third phase, it can be seen how Kieron's anxieties of our meetings and not meeting are managed in a much more contained way. His vulnerability emerges and is quite visible and known in the room and shared with Davina. Kieron also demonstrates here is nervousness when he feels there are potential conflicts between himself and Davina. He is able to think, question and check these out with Davina, and when uncertain of himself, he reverts to old familiar safe play. Importantly, he can take in the trusted good, robust object of Davina that is present in the room, and use it for himself. The tension and struggle experienced by both Kieron and Davina in the room during phase two had subsided and the emerging atmosphere in this third phase was much more trust based and relaxed.

As mentioned above, the move between one phase and the next is not easily definable, and these delineations were not fixed. The recording of phases is chiefly a method for describing movement from one set of psychopathic behaviours at the beginning, movement into a more ambivalent state of behaviours in the second, and an emergence into a much more normal way of interacting in the third. What is important here is that there was marked improvement, and a developing sense of wholeness.

Whilst examining the coding of the commentary of all three phases, I found myself quite struck by the emerging theme of the differing ways in which Kieron used the cupboard in the room. This was not apparent whilst Kieron was in treatment, and it had not occurred to me when writing up my qualifying paper for



the Association of Child Psychotherapists, but became very noticeable following on from the coding exercise.

In the first phase he used the cupboard primarily to hide from his own smallness, which in this phase he found particularly overwhelming and scary. During this phase it seems as if Kieron felt the need for retreat and protection from some internal sense of an external annihilation. Thus retreated, he seemed to then be in a better frame of mind in which he could engage with his own sense of potency again, and once he felt contained and safe, he could re-emerge and try to engage again. The idea of the cupboard door representing a protective shield that somehow prevented him from experiencing the full impact of his own weakness is quite strong, and in this phase I would say this was quite a necessary and appropriate defence against his internal feelings of falling apart. This retreat may also of course be interpreted as his withdrawal from what he experienced as a strong female figure that was offering and maintaining clear boundaries within the session, something Kieron was not used to elsewhere in his life. He would also retreat into it when asked to do something that he did not want to do, or when reminded on an unconscious level of his size and limitations. There is a sense of his need to distance himself in order to recoup, reform and continue. Once he emerged he continued to move quickly around the room, looking at toys fleetingly, grasping at things, climbing things, jumping from things, spilling things – reminiscent of a motorised toy that flips over when it hits an object and then keeps going until another object is hit and then the process of flipping and moving on again is repeated.

The second phase sessions demonstrate the beginning of therapy. In this phase Kieron's sense of containment and engagement in the therapy is evident, coupled with his more ambiguous response towards boundary setting which demonstrates his internal struggle against being able to accept Davina as a reliable, good, and robust object, a struggle that was often re-enacted in the room. During the second phase, the cupboard seemed to be used more as a reassuring space; when Kieron felt that Davina had introduced something into the room that he found different from his internal thinking (that placed him in opposition to me) he would again retreat e.g. my comments of *"I don't want you to do that"* or *"get down it's unsafe up there"*. There were lots of commands to

“find me” “look for me here” “search everywhere” that reveal an urgent sense of desperation of being remembered, and worth finding. Perhaps when confronted by my introduction of boundaries in a thoughtful way Kieron experienced this as a loss of himself, and he felt confused. By asking me to find him, it is like he was asking for himself to be found, as if he had lost something and was struggling to try to balance this out internally.

Also imbedded in the second phase is the idea – at least in my mind – of a regulatory space that was provided by the cupboard. Kieron would often start the session in the cupboard, and after a short spate of familiar play (hide and seek) he would emerge. To me, the cupboard seemed to be used like a buffer or a kind of ‘transforming container’, that marked the barrier between the external world and the internal space of the therapy room, and Kieron used it on an unconscious level as recognition of his own regulatory needs. Another theme to emerge in this phase was that of more repetitive familiar play, which I feel helped Kieron to self-soothe once he emerged from the cupboard again. This play reassured him that not all of him had been lost, and it seemed to modify his sense of confusion. He is seen in the sessions presented in this phase as being a much more vulnerable little boy, who asks me directly to help. The containment offered during his therapy is seen in this phase to have been recognised by Kieron as something reliable and good, and he is able to share a problem with me with the notion that I can be trusted to help.

In the third phase, the cupboard was still used as a retreat, and reassuring space, as a place to hide, to put shopping – his fruit - as a demonstration of something experienced externally (i.e. a McDonalds drive through), but also at times as a violent receptacle – e.g. Kieron crashed into it with a chair. So the notion that the cupboard can be attacked, be quite resilient and withstand his angry blows is also apparent. When the clinic moved, in the absence of an open cupboard that could be used, he adapted his use of the couch, chairs and blankets to provide an equivalent space. The cupboard in the new room was locked, and this was often crashed into and interpreted as an attack on the loss of a familiar containing space. I believe that the use of the cupboard is a direct reflection of Kieron’s internal world and the anxieties and complexities that it contains. I think the increased variety of differing ways that Kieron developed to

utilise the cupboard and the loss of an open door cupboard may be also be a reflection of his increased ability to think creatively, adapt and to play imaginatively within the containing environment offered by the new therapy room.

It is only on analysing this data again for this thesis that I am fully aware of just how desperate Kieron's need for a container was. Initially the cupboard was a physical empty space, a retreat, but I believe it was a symbolic representation of an internal unrequited need. He needed space in the mind of another that seemingly had been unavailable in a consistent form since his birth – a space in which he could be himself and be allowed to develop free from hostile projections, and away from Viviane's own unconscious madness.

The feeling of emptiness that I believe Kieron felt within him, I can only imagine as being quite terrifying for him. His mother had two other children to manage, and just after Kieron's birth his father was imprisoned. This must have been a very difficult time indeed for Viviane; her husband imprisoned at the time when she most needed his help and support; three children, and the love of her life was painfully absent. Reports from school (disclosed to the Principal Social Worker) suggest that her older two children missed a great deal of school during this initial period of imprisonment, and Viviane would arrive late at the school, or simply not be 'together enough' to ensure they got there at all. The school staff thought that Viviane was taking drugs during this difficult period, and this was substantiated by members of staff who lived in the area who reported that it was common knowledge that Viviane's house was a place where drugs might be obtained.

There was a real sense when re-reading the material for this thesis of whose ADHD am I witnessing? Was it Viviane's, Kieron's or both? Mum presented at the clinic with many of the symptoms that are listed as requirements for ADHD herself. Viviane's circular negative thoughts and focus seemed to indicate that she herself was preoccupied and emotionally unavailable to focus on her son's communications in any other way but from a negative symptom led perspective, where she saw herself as the victim.

In children continual activity or preoccupation of the mind may be an indication that the child is defending itself from the terror of overwhelming feelings of panic, fear and depression – a useful defence against having to deal with unwanted disturbing thoughts and feelings on one's own, these symptoms although noticeable in Kieron, were mirrored in Viviane and vice versa. If Viviane was unconsciously living this kind of pre-occupied, absent, and at times depressed life, it is not surprising that Kieron has grown up to internalise these behaviours, it has in effect, been transmitted from mother to child as a containment failure. Kieron's communications were not understood, received, or given back to him in a more digestible form, how could they be? Viviane was already suffering from the severe loss of her husband, and what she perceived as his pivotal role within the family. Her mind was very much pre-occupied elsewhere, and I imagine that due to this, Kieron may have been experienced by Viviane as being a burden to an already overloaded mind. Viviane would have wanted to hold on to Kieron (as the image of her missing husband), but the idea of trying to contain such behaviour would have proved, and did in fact prove to be, too much for her.

Where there are inner stresses that adversely influence the care giving relationship the baby has no alternative than to fit into what he finds and adapt his responses and the neurobiology behind them to the only world he knows (Balbernie, 2001).

Schore (Schore, 2001), notes that during critical periods of intense synapse production, such as early infancy, developing infants (as this is the time of their most rapid brain growth) are more sensitive to conditions in their external environment. Further, that if their external environment conditions are outside the normal range, a permanent arrest of development occurs in them.

There is a strong sense that for Kieron his external environment was far from normal. Viviane experienced post natal depression and was – as mentioned above – preoccupied with her lost love and parental responsibilities. Perhaps some of Kieron's extreme behaviours were an unconscious attempt to gain some sense of his having an impact on Viviane's mind? As Viviane was emotionally preoccupied elsewhere, it would have been difficult for Kieron to

find a place in his mother's mind. Perhaps Kieron unconsciously felt the need to act out in such a dramatic manner in order for it to register in Viviane.

I suggest that this would have led to Kieron having to constantly defend himself from feelings of disintegration – almost like a fight or flight response at best, or possibly life or death at worst. From a very young age, Kieron would have been left in the full time custody of a very depressed mother, and has subsequently introjected a dead object which seemed to be acted out in his 'dead play' in session. I mean 'dead play' in the dual sense, i.e. the play was both uninspired and it also contained lots of death and destruction.

Viviane's ability to sustain Kieron's attendance on a regular basis is to be highly commended. The amount of effort and strength of commitment she demonstrated during Kieron's psychotherapy was phenomenal especially when one bears in mind her own very emotionally deprived background. Although I have spoken about Viviane's lack of containment in this thesis, it must be borne in mind that she also had hidden attributes. Kieron certainly demonstrated the capacity to form attachments both to his parents and to myself (Bowlby, 1969), which strongly indicates that Viviane had been able to offer this as a firm basis upon which Kieron was able to build. I do not believe it was easy for her to bring Kieron so regularly for his sessions three times per week, especially when she was herself so needy. I feel it is clear from her commitment to Kieron's therapy that Viviane wanted Kieron to be different from his father, and I think it was very brave of her to bring him, especially as his attendance would undoubtedly involve her in the process of change.

I myself come from a working class background, and I believe this may have had an unconscious influence upon Viviane's acceptance of help from CAMHS. I believe my own class, coupled with my own intuitive understanding and plain spoken approach would have helped Viviane to connect to the possibility that things might be different for Kieron. I talk the language that Viviane talks and I believe that I brought my own cultural sensitivity to the sessions.

There were concerns re Viviane's neglect throughout the period of Kieron's therapy. These centred on his filthy clothes, his filthy nails, his grubby face, and his inappropriate clothes for the winter weather. My concerns were passed on

to the Principal Social Worker involved, who felt that by highlighting these shortfalls in Viviane's care, we might lose her at the clinic. Another thing that was broached, but in a roundabout way, was Viviane's inability to sustain the structure for her family during the school holidays, that was usually provided by the school routine. It was often during the school holidays that therapy became more erratic, with sessions being missed or forgotten. It was a delicate balance I feel between getting what was important for Viviane and Kieron at the time, and choosing which parts were better left unexplored. It was also a balance between the author's needs (through my training needs) and the needs of the Principal Social Worker (her own MA training need).

Looking at the research data and the marked improvement in Kieron, one cannot help but reflect that individual psychotherapy was a very beneficial intervention for him. This is especially significant as Kieron's treatment started at the very young age of four years old, or perhaps the efficacy of treatment is due to the young age at which treatment was started. Even at this young age, Kieron shows that he was hungry for some attentive and boundaried 'mothering' once it was made available to him. At this tender age he had not yet become hardened and cynical as he could so easily have become if there had been no therapeutic intervention at all. If one thinks of ADHD as being related to the lack of impulse control, and one looks at Big Kieron as Kieron's role model, it is not difficult to imagine the risks that Kieron would have grown up being exposed to on a daily basis. Big Kieron did make it very clear to the Principal Social Worker at several of their meetings that he was really pleased that Kieron was having therapy, and stated that he wished he had had that sort of help when he was Kieron's age.

One cannot state with any degree of certainty that Kieron's psychotherapy influenced his neurological development; however, this was an early intervention, and positive outcomes were observed and recorded. I had no external marker to compare or ascertain Kieron's developed neural pathways. I can only hope that Kieron's therapy has had sufficient impact to lessen his presenting symptomology as Perry (Perry et al, 1995) suggests:

*“Another major implication of a neurodevelopmental approach is that early intervention, which can ameliorate the intensity and severity of the response to trauma, will decrease the probability of developing, in a use-dependent fashion, sensitized neural systems resulting in either persisting hyperarousal or dissociative symptoms, or both”. (Perry et al, 1995)*

Balbernie (Balbernie, 2001) asserts that early events determine which circuits will be reinforced and retained. In his paper entitled *“Circuits and Circumstances: the Neurobiological Consequences of Early Relationship Experiences and How They Shape Later Behaviour”*, Balbernie quotes Bownds, (Bownds,1999), Karr-Morse & Wiley (Karr-Morse & Wiley, 1997) and Thomas (Thomas, 1995) to emphasise the consequences of what a detrimental early environment has upon a child:

*“During brain growth there is a constant sorting and juggling of nerve cells and connections. Those that make a match with their environment thrive, and the others wither.” (Bownds, 1999)*

And also (Karr-Morse & Wiley, 1997):

*“Abuse and neglect in the first years of life have a particularly pervasive impact. Pre-natal development and the first two years are the time when genetic, organic, and neurochemical foundations for impulse control are being created. It is also the time when the capacities for rational thinking and sensitivity to other people are being rooted – or not – in the child’s personality” (Karr-Morse & Wiley, 1997)*

*Detrimental early experiences and subsequent neurobiological damage can cause a child to develop a range of problems including hyperactivity associated with disruptive behaviour and distractibility or hypervigilance. (Thomas 1995)*

These viewpoints point to the importance of ‘normal’ early development and the injurious consequences of a disruptive, traumatic start on neurological development. Balbernie points out that the brain has an innate ability to change its own structure in response to the environment in which it lives

(neuroplasticity) and that infancy and adolescence may be the periods of greatest neurological plasticity (Balbernie, 2001). This supports the idea of early intervention being the most effective way of changing existing neural pathways in traumatised young people. Encouragingly, Schore (Schore, 1997) states that although *“Opportunities and risks are greatest during the first years of life, learning takes place throughout the human life cycle”* (Schore, 1997)

I believe that Kieron demonstrated his capacity to grow and learn within the clinical setting and also show marked improvement in his external environment, and I agree with Balbernie’s (Balbernie, 2001), assertion that we *“can do something for maltreated infants and their families if we have the resources”*. I would also wholeheartedly agree with Schonkoff & Phillips (Schonkoff & Phillips, 2000) assertion that:

*“the course of development can be altered in early childhood by effective interventions that change the balance between risk and protection, thereby shifting the odds in favour of more adaptive outcomes”.*  
(Schonkoff & Phillips, 2000)

There are currently no universally accepted biological markers for ADHD and there are no definitive behavioural tests on which a diagnosis can be based. The current tests used in my clinic are known as SNAP IV’s (Appendix 1), which are circulated to parents and schools for completion. These are returned to the clinic psychiatrist for evaluation and if necessary medication. The NICE Guidelines, (2008) now specify that the symptoms described need to be observed in two separate settings i.e. home and school, but I have a very strong sense that this does not go far enough to evaluate whether a child has ADHD.

I have witnessed psychiatrists looking down the parental responses to the SNAP IV’s and ignoring them as they are deemed to be too extreme, preferring to look at the more ‘objective’ viewpoint of the school, but both views are subjective. The ability of teachers to be able to contain and manage difficult behaviour is also subjective. Although timely and initially less cost effective, perhaps it would be beneficial if psychiatrists were able to spend time observing the child in school before they medicate – in the long run this might prove to be more cost efficient. Another worrying thing that I have heard recently is that of



forceful mother's bringing their children to see the psychiatrist and insisting that their child receive medication – almost as if it is a right. I have also heard from one psychiatrist and a behavioural nurse that mothers in impoverished areas meet together to offer each other support in how to obtain a diagnoses, medication and the current permissible benefits available for their child. As mentioned above, this is a somewhat perverse system that is in place, which can only lead to a perverse response in the more financially vulnerable.

My personal opinion is that this 'silencing' of the child and his behaviours through medication are tantamount to infringing upon their human rights, it is I believe, in some instances, a form of Munchausen by proxy, and abusive. It might reasonably be seen as worrying when members of the psychiatric profession could to some extent be seen as colluding with this by medicating, especially where psychiatrists are offering a diagnosis for ADHD without the need for medication to be offered. This sounds almost farcical, as it would seem to point to the fact that a parent would – within the current system - be entitled to pursue for a diagnosis, and also claim for allowable benefits, but their child would not be helped with their behaviour through the use of medication. One would have to question the reason for pursuing such a diagnosis in the sense of *how would this help their child?*

When considering Main's research which explores the clinicians own need to 'do something' for their struggling patients, (Main, 1957) I am left wondering whether the ease with which prescriptive drugs and diagnosis for ADHD are distributed might also be a reflection of the clinician's own need to 'do something' to alleviate the complex and unmanageable situations being presented in their clinic. This would quite possibly need further exploration by clinicians. The response to medicate might, I feel, in some instances represent a 'knee jerk' response to the overwhelming unmanageable symptoms that are projected into the clinician by the parents when describing their child's unmanageable behaviour. A 'knee jerk response' could be interpreted as an ADHD type response i.e. it is impulsive, the consequences of such a diagnosis is not thought through, and insufficient attention is paid to the underlying relationships which might be causing some of the symptoms. I wonder how many psychiatrists would recommend ADHD medication for their child.

In the Guardian Newspaper, 18<sup>th</sup> March 2011, an article written by Rowenna Davis quotes Professor Tim Kendell joint director of the National Collaborating Centre for Mental Health, who chaired the NICE Guidelines Committee as saying:

*“...children in nursery and pre-school are being prescribed medication unnecessarily, and it is often parents who were putting pressure on GP’s”*

Kendell also stated that prescription numbers could continue to increase due to impending health cuts:

*“It’s a false economy... all the evidence says that parent training courses combined with partnership with schools is what works, but these programmes are being cut by local councils”*

The description that I have just outlined above would not be difficult to imagine given the pressurised atmosphere of current day employment within the NHS where the push is to see as many patients in as short a time as possible, perhaps yet another example of ADHD symptomology? The reaction of some psychiatrists to medicate the problem of ADHD like behaviour in such a way may well be a spontaneous one, something they have been familiar with and are happy to do for a long period of time (i.e. it has become habitual); it is one way of relieving the distress that some parents present at CAMHS clinics.

## **Recommendations**

### **Service**

- 1 I would recommend that child psychotherapy be included in the NICE Guidelines as an alternative method of treating children with ADHD symptomology – particularly for young children under the age of 5 years.
- 2 I would like to recommend more attention to be paid to environmental aspects when assessing a child for ADHD symptomology – to avoid too early a diagnosis and premature medication.
- 3 I would advocate increased access for families to parenting groups to help them manage their child's behaviour – avoiding the 'hands off' approach mentioned previously.
- 4 The current provision of benefits seems to be in need of re-evaluation in light of their perverse nature i.e. seeming to financially reward parents for having children with ADHD symptomology
- 5 I would propose that money currently being directed towards medication and the current benefit system might reasonably be re-directed for the purposes listed in 1,2 & 3 above.

### **Clinical**

- 1 I would like to see more psychotherapists using their skills clinically with children with ADHD symptomology prior to diagnosis and treatment
- 2 I would encourage more child psychotherapists to offer individual work to young people at risk of a diagnosis of ADHD
- 3 I would hope that this thesis and some of the material contained within it would encourage clinicians to look beyond the symptomology and seek to understand the young person's lack of containment

## **Research**

- 1 I would suggest further research into what kind of psychotherapy intervention at a relatively low cost can be thought about in today's climate. This would, of course, require further work and analysis.
- 2 I propose that the understanding of the symptoms of ADHD in CAMHS clinics be deepened, recognising that this condition is more than 'a bundle of symptoms'. I hope that my research has shown that attention to a child's primary relationships, and to what psychoanalytic psychotherapy sees as its 'internal world', can address aspects of this condition. Perhaps psychotherapy might be offered in conjunction with medication
- 3 Further research into whether equally satisfying results might be achieved with different types of engagement in therapy is needed i.e. experimentation with not necessarily intensive, but 1 x 30 weeks, or 2 x 20 weeks psychotherapy treatments.

## Conclusion

According to NICE Guidelines, (2008) between 1% and 9% of young people in the UK now have some form of ADHD, depending on the criteria used. NHS figures show a rise in all methylphenidate prescriptions across all age groups by almost 60% in five years, rising from 389,200 in 2005 to 610,200 in 2009. Psychiatrists agree that when attempting to diagnose at such a young age there is an increased possibility of mis-diagnosis or too early a diagnosis. My hypothesis based on this single case study would therefore be that young children who may have a prognosis of ADHD appear to benefit from a thoughtful, containing environment without the need for medication and labelling. It may be argued that perhaps if a qualified child psychotherapist were to see a child instead of a much less experienced trainee then perhaps fewer sessions per week may be sufficient. (My work with this child was undertaken as part of my specialist child psychotherapy training, and was intensive in part for this reason.) I cannot fully explore this issue at this time, but it is food for thought when putting forward the idea that a child can be all too easily diagnosed with a condition, that might respond in a positive way to individual psychotherapy – intensive or otherwise. What I can say is that since qualification I have seen two patients with a diagnosis of ADHD on a once weekly basis over the period of one year and there has been a marked improvement in their ability to regulate their impulsivity. Although these two cases are not comparable in the sense that the children are much older (10 & 12yrs) and both are looked after by paternal grandparents, I do feel that early containment failure has been present in all three cases. Perhaps such improvements in older children, who are seen on a once weekly basis is sufficient to contribute to the body of this thesis; namely the efficacy of child psychotherapy with children who have ADHD symptomology.

The implications for having an alternative method of dealing with these children whose numbers appear to be significantly rising in the UK mirroring the mushrooming USA figures, is that they do not necessarily have a diagnosable condition, and also they may not need to receive potentially dangerous medications. I find myself in agreement with the view that:

*"It is so much easier for adults to live with a diagnosis of ADHD than with 'failure'" (Timini, 2005).*

Once the diagnosis exists, the parents can in effect 'wash their hands of responsibility', and adopt the stance that *'it's not our fault, he has ADHD, and we can't do anything about it'* i.e. *'it's not us, it's him!'* Indeed, in the second year of treatment, Kieron would sometimes come to his sessions and tell me that he had ADHD – he was only 5 years old and the supposition was that he had gleaned this idea from whom? When the Principal Social Worker took this up with Viviane, she denied having told Kieron that he had ADHD, but where else could he have heard this? Viviane was unable during the course of Kieron's treatment to confront any of her own issues and her own need to project so violently and negatively into Kieron, she was only able to catalogue his misdemeanours as if they had occurred spontaneously and he was – as she and family referred to him – evil. My hope is that she has since during the course of her own therapy been able to at least make a start to examine this aspect of her personality.

The other huge implication of ADHD diagnosis and treatment is that of the financial burden on the government. The children who are diagnosed aged 5 years old are effectively labelled for life. They will grow up to become adults who will be dependent upon the State for financial support, and destined to live an impoverished deprived life with little room for personal development and growth. Families of children with a diagnosis of ADHD can currently receive Disability Living Allowance and Carer's Allowance which when added together totals an allowance amounting to around £500 per month. There are of course families for which a diagnosis is totally justified and the money received is vital in enabling their family to function and maintain 'normal' living - these are often families where ADHD is a secondary diagnosis to say, for example, autism, or conduct disorders. However, the propensity to diagnose and medicate without due exploration or consideration of the underlying causes is I feel, quite negligent. It has to be noted, of course, that psychiatrists too are under extreme pressure to perform in the present climate, and that their caseloads are huge and often disproportionate to the recommended patient caseload recommended by the Royal College of Psychiatrists.

There are currently no procedures for monitoring whether children are in fact taking the medication prescribed, plus there does appear to be a gap somewhere in the existing benefit system that seems to be perverse, and open to exploitation by some. In a country where there are an ever increasing number of single parent families, £500 per month is a very large sum of money indeed. This benefit is something that is being offered, it thus is something that parents feel entitled to. This diagnosis and benefit system offers little incentive to the parents to look for improvement in their child, and offers them an 'off the hook' attitude that is deemed to be acceptable with regard to their own responsibility for and contribution towards their child's behaviour.

There is an issue of the perverse consequences of medical diagnosis for parental behaviour that I am raising here. I would suggest that parents may gain some benefit, whether it is psychological, in terms of reassurance, or more tangibly in terms of additional attention and entitlements for their child as a consequence of receiving a definitive diagnostic label. Also, there is a system in place, which might incite parents to act in a perverse manner to produce the relevant symptoms for a diagnosis – as described above. Some of the parents involved in this process are on very low incomes, and may even be single parents on very low incomes. I would suggest that the temptation for financial gain may, in some instances, prove too much. Little thought as to the long term implications of a mental health diagnosis appears to have been given. Another factor that may also give rise to the preference for a medical diagnosis is that if the child is acknowledged to have 'x' then it becomes the responsibility of the doctors, or no-one's responsibility, (except in regard to medication). There is no room for thinking about any possible sources of anxiety for the child in this model.

Other, less drastic and long lasting solutions might be consistently offered prior to the current default position of diagnoses and medication. Parenting support or classes, individual therapy for the parent(s), behaviour management strategies, child psychotherapy, art therapy, might well be a prerequisite to diagnosis and treatment or in the very least considered as viable alternatives. Attention to the underlying relationships within families should be fully explored prior to any diagnosis being given, the gravity of such a diagnosis is a heavy

burden for a small child to carry, and it is a burden that unfortunately does not lessen with age.

I hope that the thesis material and the thoughts and recommendations written herein will contribute towards the body of knowledge of Child Psychotherapy and ADHD treatment. I would like to think that some of the ideas and thoughts expressed will be helpful to other professionals who may be evaluating whether Child Psychotherapy is a viable alternative to diagnosis and treatment. Certainly within my own clinic, this has already been the case.



## References

**Ainsworth, M, Waters, E, Wall S (1978),** *Patterns of Attachment: A Psychological Study of The Strange Situation*, Hillside , New Jersey, USA

**Arcelus J, Vostanis, P (2003),** *Child Psychiatric Disorders Among Primary Mental Health Service Attenders*, British Journal of General Practice, Vol.53, pp 214-216

**Anderson, J (2001),** *Risk Taking Dangerous Behaviour in Childhood*, Doctoral Thesis, The Tavistock Clinic, London

**Anderson, J (2003),** *Mythic Significance of Risk Taking, Dangerous, Behaviour*, Journal of Child Psychotherapy, Vol. 29, No. 1, pp 75-91

**Bailly, L (2005),** *Stimulant medication for the treatment of attention-deficit hyperactivity disorder: evidence-b(i)ased practice?* Psychiatry Bulletin, Vol. 29, pp 284 - 287

**Balbernie, R (2001),** *Circuits and Circumstances: the Neurobiological Consequences of Early Relationship Experiences and How They Shape Later Behaviour*, Journal of Child Psychotherapy, Vol. 27, (3), pp 237-255

**Balint, M (1957),** *The Doctor, His Patient and the Illness*, International Universities Press, New York

**Barkley RA (1998),** *Attention-deficit hyperactivity disorder: a handbook*, Guilford Press, New York

**Bick, E (1968),** *The Experience of the Skin in Early Object Relations*, International Journal of Psycho-Analysis, Vol. 49, pp484-486

**Bion W (1962),** *Learning from Experience*, Karnac, London

**Bion, W (1964),** *Container and Contained in Attention and Interpretation*, Karnac, London

**Bion W (1967),** *Second Thoughts*, Karnac, London

**Bobb, A, Castellanos, FX, Addington, A, Rapoport, AL (2004),** *American Journal of Medical Genetics, Part B: Neuropsychiatric Genetics*, Vol. 141B (6) pp 551-565

**Boehrer, J (1990),** *Teaching With Cases: Learning to Question*, New Directions for Teaching, No. 42, p 41-57

**Boston, M, Szur, R (eds) (1983),** *Psychotherapy with Severely Deprived Children*, Karnac Books, London

- Bowlby, J (1969),** *Attachment and Loss Vol.1 Attachment*, Hogarth Press, London
- Bownds, MD (1999),** *The Biology of Mind*, Fitzgerald Science Press, Bethesda
- Bramble,D (2003),** Annotation: *The use of psychotropic medications in children: A British view*, Journal of Child Psychology and Psychiatry, 44(2), 169-179
- British Psychological Society (2000),** *Attention Deficit / Hyperactivity Disorder Guidelines and Principles for Successful Multi-Agency Working*, BPS, London
- Cadore, R, Yates, W, Troughton, E, Woodworth, G, & Stewart, M (1995),** *Genetic-Environmental Interaction in the Genesis of Aggressivity and Conduct Disorders*, Archives of General Psychiatry Vol.52, pp 91 6
- Campbell, DT (1975),** *Degrees of Freedom and the Case Study*, Comparative Political Studies 8 178-193
- Caper R (1999),** *A Mind of One's Own: A psychoanalytic view of self and object*, Routledge, London
- Charmaz, K (2006),** *Constructing Grounded Theory*, Sage, London
- Cicchetti, D & Rogosch, F (1996),** *Equifinality and Multifinality in developmental psychopathology*, Developmental Psychopathology Vol. 8, pp 597-600
- Chu, S (2003),** *Occupational Therapy for Children with Attention DeficitHyperactivity Disorder: a survey on the level of involvement and training needs of Therapists*, British Journal of Occupational Therapy, Vol. 66 (5), pp 209-218
- Cleve, E (2004),** *From Chaos to Coherence*, Karnac, London
- Conrad, P & Potter,D (2000),** *From Hyperactive Children to ADHD Adults: Observations on the Expansion of Medical Categories*, Social Problems Vol. 47 (4), pp 559-582 University of California Press, USA
- Cooke, T & Campbell J (1979),** *Quasi-Experimentation*, Houghton Mifflin, Boston, USA
- Damasio, A (2000),** *The Feeling of What Happens*, Vintage, London
- Denham, S, Workman, E, Cole, P, Weissbrod, C, Kendziora, K & Zahn-Wexler, C (2000),** *Prediction of Externalising Behaviour Problems from Early to Middle Childhood: The Role of Parental Socialisation and Emotion Expression*, Development and Psychopathology Vol. 12, pp 23-45
- Denzin, NK, Lincoln, YS, Robert Stake, (Eds)(1994),** *Handbook of Qualitative Research, Ch 14*, Sage, London

**Elder, GH, Pavalko, EK, Clipp, EC (1993),** *Working with Archival Data: Studying Lives: Quantitative Applications in the Social Sciences*, Sage, London

**Esser, G, Fischer, S, Laucht, M, Schmidt MH, Wyschkon, A (2007),** *Precursors of Hyperactive disorders: potential early diagnosis in infants?* Zeitschrift fur Kinder und Jugendpsychiatrie und Psychoteherapie, Vol. 35, (3), pp 178-88

**Farrington (2001),** *The Cambridge Study, First 40yrs of the Case Study in Delinquent Development (2001)- in Taking Stock of Delinquency: An Overview of Findings from Contemporary Longitudinal Studies*, Plenum Press, New York

**Fonagy P & Moran G (1983),** *Selecting Single Case Research Designs for Clinicians, Chapter 5, - Psychodynamic Treatment Research – in A Handbook for Clinical Practice*, Miller N, Luborsky L, Barber J, Docherty J, Basic Books, New York

**Fraiberg, S (1975),** *Clinical Studies in Infant Mental Health – The First Year of Life, Chapter 7, Ghosts in the Nursery: A Psychoanalytic Approach to the Problems of Impaired Infant-Mother Relationships*,(Fraiberg, S, Adelson, E, Shapiro, V), Tavistock Publications London

**Freud, S (1900),** *The Interpretation of Dreams*, Hogarth Press, London

**Freud, S (1909),** *Analysis of a Phobia in a Five-Year-Old Boy*, Standard Edition X, Hogarth Press, London

**Freud, S (1912),** *Recommendations to Physicians Practising Psycho-analysis*, Standard Edition XII, Hogarth Press, London

**Freud, S (1918),** 'Wolf Man', *The History of an Infantile Neurosis*, Standard Edition, XVII, Hogarth Press, London

**Freud, S (1923),** *The Infantile Genital Organisation*, Standard Edition, Vol. 19, Hogarth Press, London

**Freud, S (1926),** *Inhibitions, Symptoms and Anxiety*, Standard Edition XX, Hogarth Press London

**Freud, S (1955),** *Notes Upon a Case of Obsessional Neurosis*, Standard Edition, X, 151-249, Hogarth Press, London

**Furman, L (2006),** *Journal of Child Neurology*, Vol. 20 No. 2, pp 994-1002

**Geertz, C (1973),** *Description: Toward and Interpretative Theory of Culture, Ch.1, The Interpretation of Culture*, Basic Books, New York

**Geertz, C (1985),** *Local Knowledge: Further Essays in Interpretative Anthropology*, Basic Books, New York

**Gerhardt, S (2004),** *Why Love Matters: how affection shapes a baby's brain*, Routledge, London

**Gilmore, K (2000)**, *Diagnosis, Dynamics, and Development: Considerations in the Psychoanalytic Assessment of Children with ADHD*, *Psychoanalytic Inquiry* Vol. 22 (3), pp 372-390

**Giovacchini, PL (1972)**, *Tactics and Techniques in Psychoanalytic Therapy*, Science House, USA

**Glaser, B & Strauss, A (1967)**, *The Discovery of Grounded Theory: Strategies for Qualitative Research*, Transaction Publishers, Brunswick, USA

**Greenwald, A, Pratkanis, A, Leippe, M, Baumgardner, M (1986)**, *Under What Conditions Does Theory Obstruct Research Progress?* *Psychological Review*, Vol. 93, pp 216-229

**Hacking, I (1995)**, *Rewriting the Soul: Multi Personality and the Science of Memory*, Princeton University Press, Princeton USA

**Hacking, I (1999)**, *The Social Construction of What?*, Harvard University Press, London

**Hammersley, M (1995)**, *The Politics of Social Research*, Sage, London

**Harding, J (1998)**, *What are the gaps and why? Services for Mentally Disordered Offenders*, Young People Conference Paper of the Royal College of Physicians

**Harré, R (1979)**, *Social Being*, pp132-135, Blackwell, Oxford

**Harrington, R, McGuffin, P, Thapar, A (2001)**, *Examining the Comorbidity of ADHD-Related Behaviours and Conduct Problems Using a Twin Study Design*, *British Journal of Psychiatry*, Vol. 179, pp 224-229

**Hawes, DJ, Dadds, MR (2005)**, *The Treatment of Conduct Problems in Children With Callous-Unemotional Traits*, *Journal of Consulting and Clinical Psychology*, Vol. 73(4), pp 737-741

**IJPA (1995)**, *International Journal of Psychoanalysis 75th Anniversary April 1995: On Clinical Facts*, Sao Paolo

**Jensen, P, Hinshaw, S, Swanson, J, Greenhill, L, Conners, C, Arnold, L, Abikoff, H, Elliot, G, Hechtman, L, Hoza, B, March, J, Newcom, J, Severe, J, Vitiello, B, Wells, K \* Wigal, T (2001)**, *Findings from the NIMH Multimodal Treatment Study of ADHD (MTA): Implications and Applications for Primary Care Providers*, *Journal of Developmental & Behavioural Paediatrics*, Vol. 22 (1), pp 60-73

**Jensen, P, Arnold, L, Swanson, J, Vitiello, B, Abikoff, H, Greenhill, L, Hechtman, L, Hinshaw, S, Pelham, W, Wells, K, Conners, C, Elliott, G, Epstein, J, Hoza, B, March, J, Molina, B, Newcom, J, Severe, J, Wigal, T, Gibbons, R, & Hur, K (2007)**, *Journal of the American Academy of Child & Adolescent Psychiatry*, Vol. 46, (8), pp 989-1002

**Jayson, A (2010)**, *ADHD: What every parent needs to know*, in article by Charlotte Haigh, Mirror Newspaper Group, 8<sup>th</sup> October, 2010, London

**Johnson, AM, & Szurek, SA (1952),** *The Genesis of Antisocial Acting Out in Children and Adults*, Psychoanalytic Quarterly, Vol. 21, pp 323-343

**Jones, B & Allison, L (2010),** *An Integrated Theory for Attention-Deficit Hyperactivity Disorder (ADHD)*, Psychoanalytic Psychotherapy, Vol.24, Issue 3, pp 279-295

**Joseph, B (1989),** *Psychic Equilibrium & Psychic Change, Selected Papers of Betty Joseph*, Routledge, London

**Karr-Morse, R, Wiley, M (1997),** *Ghosts From the Nursery: Tracing the Roots of Violence*, The Atlantic Monthly Press, New York.

**Kessler, RC, Adler, L, Barkley, R, Biederman, J, Conners, CK, Demler, O, Faraone, SV, Greenhill, LL, Howes, MJ, Secnik, C, Spencer, T, Bedirhan Usten, T, Walters EE, Zaslavsky MS, Zaslavsk, A, (2006),** *The Prevalence and Correlates of Adult ADHD in the United States: Results from the National Co-morbidity Survey Replication*, American Journal of Psychiatry, April 163(4), pp 716-723

**Kidd, PM (2000),** *Attention Deficit/Hyperactivity Disorder in Children: Rationale for its Integrative Management*, Alternative Medicine Review, Vol. 5(5), pp 402-428

**Klein, M (1932),** *The Psycho-Analysis of Children, Ch X Early Anxiety Situations*, Hogarth Press, London

**Klein, M (1957),** *Envy & Gratitude, Ch10 Envy & Gratitude*, Hogarth Press, London

**Klein, M (1961),** *Narrative of a Child Analysis*, Hogarth Press, London

**Kraemer, S (1988),** *The Civilisation of Fathers*, Tavistock Public Lecture

**Kratochvil CJ, Heiligenstein JH, Dittmann R, Spencer T, Biederman J, Wernicke J, (2002),** *Atomoxetine and methylphenidate treatment in children with ADHD: a prospective, randomized, open-label trial*. Journal of the American Academy of Child and Adolescent Psychiatry. 2002;Vol. 41,pp 776–784

**Lakhan, S, Hagger- Johnson, GE (2007)** ,*The Impact of Prescribed Psychotropics on Youth*, Global Neuroscience Initiative Foundation, Los Angeles, CA, USA

**Leuzinger-Bohleber, M, Target, M, Canestri, J,** *Early Development & Its Disturbances: Clinical, Conceptual & Empirical Research on ADHD & Other Psychopathologies & Its Epistemological Reflections*, Karnac, London

**Luria, A (1968),** *The Mind of a Mnemonist*, Basic Books, New York

**Lush, D, Boston, M & Grainger E (1991),** *Evaluation of Psychoanalytic Psychotherapy with Children: therapists' assessments and predictions*, Psychoanalytic Psychotherapy Vol. 5 (3), pp 191-234

**Lynam, D. R. (1996),** *Early Identification of Chronic Offenders: Who is the fledgling psychopath?* Psychological Bulletin, Vol.120, pp 209-224

**Lynam, D. R. (1997),** *Pursuing the Psychopath: Capturing the fledgling psychopath in a nomological net*, Journal of Abnormal Psychology, Vol.106, pp 425-438

**Lynam, D. R. (1998),** **Early identification of the fledgling psychopath: Locating the psychopathic child in the current nomenclature**, Journal of Abnormal Psychology, Vol.107, pp 566-575

**MacDonald, JM (1963),** *The Threat to Kill*, American Journal of Psychiatry, Vol. 120,(2),pp125–130

**Main, M, Kaplan, N, Cassidy, J (1985),** *Security in Infancy, Childhood and Adulthood: A Move to the Level of Representation*, Bretherton, I & Waters, E, *Growing Points of Attachment Theory and Research*, Monographs of the Society for Research in Child Development, Vol. 50, University of Chicago Press, Chicago

**Mash, EJ, & Wolfe, DA (2007),** *Abnormal Child Psychology*, 4<sup>th</sup> Ed, Cengage Learning, Wadsworth

**Mealey, L (1995),** *The Sociobiology of Sociopathy: an Integrated Evolutionary Model*, Behavioural and Brain Sciences Vol. 18, pp 523-99

**Merriam, SB (1985),** *The Case Study in Educational Research: A review of Selected Literature*, Journal of Educational Thought, Vol.19 (3), pp 204-17

**Minnis, H et al. (2006),** *The Computerized MacArthur Story Stem Battery - a pilot study of a novel medium for assessing children's representations of relationships*. International Journal of Methods in Psychiatric Research, Vol. 15, pp. 207-214.

**McGuinness,D (1989),** *Attention Deficit Disorder: The Emperor's Clothes, animal "pharm", and other fiction*. In Fisher, S and Greenberg, RP (Eds) *The Limits of Biological Treatments for Psychological Distress: Comparisons with Psychotherapy and Placebo*, Erlbaum, pp 151-88, Hillsdale, NJ USA

**Mc Guire, W (1983),** *A Contextualist Theory of Knowledge: Its Implications for Innovation and Reform in Psychological Research*, in L Berkowitz (ed) *Advances in Experimental Social Psychology* (Vol 16 pp 1-47) Academic Press, New York

**Mc Kenzie I, Wurr C (2004),** *Diagnosing and treating attentional difficulties: a nationwide survey*, Archives of Disease in Childhood, 89 (10), 913-916

**Neven R, Anderson V, Godber, T (2002),** *Rethinking ADHD – Integrative Approaches to Helping Children at Home and at School*, Allen Unwin, Australia

**Orford, E (1998),** *Wrestling with the whirlwind: an approach to the understanding of ADD/ADHD*, Journal of Child Psychotherapy, Vol.24 No.2 pp253-266

**O'Reilly, K (2000),** *The British on the Costa del Sol: Transnational Identities and Local Communities*, Routledge, London

**O'Shaughnessy, E (1994),** *What is a Clinical Fact?* The International Journal of Psychotherapy, Vol. 75, pp 939-947

**Palmer, E & Finger, S (2001),** *An Early Description of ADHD (Inattentive Subtype): Dr Alexander Crichton & "Mental Restlessness" (1798)*, Child Psychology and Psychiatry Review ( 2001) Vol.6 Issue 2

**Panksepp, J (2002),** *On the animalian values of the human spirit: the foundational role of affect in psychotherapy and the evolution of consciousness*, European Journal of Psychotherapy, Counselling & Health, Vol. 5, No. 3, pp 225-245

**Panksepp, J (1998),** *Attention deficit disorders, psychostimulants, and intolerance of childhood playfulness: a tragedy in the making*, Current Directions in Psychological Sciences, 7:91-8

**Perelberg, R (Ed) (1999),** *Psychoanalytic Understanding of Violence and Suicide*, New Library of Psychoanalysis, Vol.33, pp6, Routledge, London

**Perry, BD, Pollard, R, Blakely, T, Baker W & Vigilante, D (1995),** *Childhood Trauma, the neurobiology of adaptation and "use-dependent" development of The Brain: How "States" Become "Traits"*, Infant Mental Health Journal, Vol.16 (4) pp 271-291

**Pinker, S (2002),** *The Blank Slate*, Penguin, Harmondsworth

**Pozzi, M E (2000),** *Ritalin for Whom? Understanding the need for Ritalin in psychodynamic counselling with families of under-5's*, Journal of Child Psychotherapy Vol. 26, No 1, pp25-43

**Pulkkinen, L & Pitkanen, T (1993),** *Continuities in Aggressive Behaviour from Childhood to Adulthood*, Aggressive Behaviour Vol. 19 pp263

**Ramsland, K (2010),** *The Forensic Psychology of Criminal Minds*, Berkeley Publishing, New York, USA

**Reid, S (1990),** *The Importance of Beauty in the Psychoanalytic Experience*, Journal of Child Psychotherapy, 1990, Vol. 16, No.1

**Reid, S (Ed) (1997),** *Developments in Infant Observation, The Tavistock Model*, International Journal of Psychoanalysis Vol.81, pp825-829, Routledge, London

**Reid, S (1997),** *The Generation of Psychoanalytic Knowledge: Sociological and Clinical Perspectives Part Two: Projective Identification – The Other Side of the Equation*, British Journal of Psychotherapy, Vol. 13, (4), pp542-554

**Rustin, M (1999)**, *The Training of Child Psychotherapists at the Tavistock Clinic: Philosophy and Practice*, *Psychoanalytic Inquiry*, 19:125-141

**Rustin, M, Quagliata, E (Eds) (2000)**, *Assessment in Child Psychotherapy*, Karnac, London

**Rustin, M (2001)**, *Research, Evidence and Psychotherapy*, in *Evidence in the Psychological Therapies* Chris Mace, Stirling Moorey & Bernard Roberts (Eds), Routledge, London

**Rustin, M (2002)**, *Reason and Unreason: Psychoanalysis, Science and Politics*, Continuum Books, London

**Rustin, M (2009)**, *Child Psychotherapy and Research: New Approaches, Emerging Findings*, in Part 1, Chapter 2 What do Child Psychotherapists Know? Midgley, Anderson, Grainger, Nesic-Vuckovic and Urwin (Eds), Routledge, London

**Ryan, S (1999)**, *Genetic susceptibility to neurodevelopmental disorders*, *Journal of Child, Psychology and Psychiatry*, Mar 1999, Vol. 14, (3) pp 187-196

**Sacks, O (1985)**, *The Man Who Mistook His Wife For A Hat*, Macmillan, London

**Salomonsson, B (2006)**, *The Impact of Words on Children with ADHD and DAMP*, *International Journal of Psychoanalysis* Vol. 87 pp 1029-1047

**Sayer, A (1992)**, *Method in Social Science: A Realistic Approach*, 2<sup>nd</sup> Ed, pp 241-251, Routledge, London

**Schore, AN (1997)**, *Rethinking the Brain: New Insights Into Early Development*, Families and Work Institute, New York.

**Schore, AN (2001)**, *The Effects of Early Relationship Trauma on Right Brain Development, Affect Regulation, and Infant Mental Health*. *Infant Mental Health Journal*, Vol. 22 (1-2) pp 201-269

**Seidman, L J, Makris, N, Valera, EM (2005)**, *Structural Brain Imaging of Attention-Deficit/Hyperactivity Disorder*, *Biological Psychiatry*, Vol. 57 (11) pp 1263-1272

**Shirk, S, Talmi, A, Olds, D (2000)**, *A Developmental Psychopathology Perspective on Child and Adolescent Treatment Policy*, *Development and Psychopathology* Vol. 12 pp 835-855

**Shonkoff, JP, Phillips, DA Eds (2000)**, *From Neurons to Neighbourhoods: The Science of Early Childhood Development*, National Academy Press, Washington DC

**Shuttleworth, (1989)**, *Psychoanalytic theory and infant development: Closely Observed Infants*, Duckworth, London

**SIGN (2001)**, *Scottish Intercollegiate Guidelines Network*, Attention Deficit and Hyperkinetic Disorders in Children and Young People Executive



**Slater, P (2009)**, *"A boy afraid of his shadow": A Study of how the experience of a violent father has impacted upon a latency boy's development and search for identity*, Doctoral Thesis, Tavistock Clinic, London

**Smith, L (1979)**, *An Evolving Logic of Participant Observation, Educational Ethnography, and Other Case Studies*, Shulma, L (Ed.), Review of Research in Education 6, Itaska, Peacock Press, Illinois

**Spence, D (1993)**, *Traditional Case Studies and Prescriptions for Improving Them, Chapter 3 in Psychodynamic Treatment Research – A Handbook for Clinical Practice*, Miller N, Luborsky L, Barber J and Docherty J, Basic Books, New York

**Stake, R E (1995)**, *The Art of Case Study Research*, Sage, London

**Strauss, A, Corbin, J (1998)** *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory*, Sage, London

**Sugarman, A (2006)**, *Attention Deficit Hyperactivity Disorder and Trauma*, International Journal of Psycho-Analysis, 2006, Vol87 (1) p237

**Swanson, J, Sargeant, J, Taylor, E, Sonuga – Barke, E, Jensen, P, Cartwell, D, (1998)**, *Attention-Deficit Hyperactivity Disorder and Hyperkinetic Disorder*, Lancet, 351 (9100), pp 429-433

**Symington, J (1985)**, *The Survival Function of Primitive Omnipotence*, The International Journal of Psycho-Analysis, Vol. 66, pp481-487

**Taylor, E, Chadwick, O, Heptinstall, E, Danckaerts, M(1996)**, *Hyperactivity and conduct problems as risk factors for adolescent development*, Journal of the American Academy of Child & Adolescent Psychiatry, 35 (9), 1213-1226

**Thapar, AK, Thapar, A (2003)**, *Attention-deficit hyperactivity disorder*, British Journal of General Practice, 53 (488) pp225-230.

**Thomas, JT (1995)**, *Traumatic Stress Disorder Presents as Hyperactivity and Disruptive Behaviour: Case Presentation, Diagnosis and Treatment*, Infant Mental Health Journal Vol. 16, (4), pp 306-317

**Timimi, S (2005)**, *ADHD: the medicalisation of naughty boys*, Human Givens Journal, Vol. 12, No2

**Turner, DC, Sahakian, BJ (2006)**, *Neuroethics of Cognitive Enhancement*, Biosocieties 2006 , Vol. 1, pp113-123

**Turpin, G. (2001)**, *Single Case Methodology and Psychotherapy Evaluation*, in Mace, C., Stirling M., Roberts, B (Eds) *Evidence in Psychological Therapies*, Routledge, London

**Vitiello, B (2001)**, *Psychopharmacology for Young Children: Clinical Needs and Research Opportunities*, Pediatrics, Vol. 108, pp 983-989

**Vitiello, B (2007),** *Research in Child and Adolescent Psychopharmacology: recent accomplishment and new challenges*, Psychopharmacology Vol. 191 pp 5-13

**Weatherby, G. A.; Buller, D. M.; McGinnis, K. (2009),** *The Buller-McGinnis Model of Serial-Homicidal Behavior:An integrated Approach*, Journal of Criminology and Criminal Justice Research and Education, Vol. 3 (1)

**Wender, PH, Reimherr, FW, Marchant, BK, Sanford, ME, Czajkowski, LA, Tomb, DA,** *A One Year Trial of Methylphenidate in the Treatment of ADHD*, Journal of Attention Disorders, Jan 2010 (online), Vol. 15, No. 1 pp 36-45, July 2011

**Widener, A J (1998),** *Beyond Ritalin: the importance of therapeutic work with parents and children diagnosed ADD/ADHD*, Journal of Child Psychotherapy Vol. 24, (2) pp 267-281

**Widlöcher, D (1994),** *A Case is not a Fact*, International Journal of Psychoanalysis, Vol. 75, pp 1233-1244

**Willock, B (1990),** *From Acting Out To Interactive Play*, International Journal of Psychoanalysis Vol.70, pp 322

**Winnicott, DW (1958),** *The Observation of Infants in a Set Situation, Through Paediatrics to Psychoanalysis, collected papers*, Karnac, London

**Winnicott, DW (1962),** *Ego Integration in Child Development in the Maturational Process and the Facilitating Environment*, Karnac Books, London

**Winnicott, DW (1960),** *The Theory of the Parent Infant Relationship, in The Maturational Processes and the Facilitating Environment*, (1965) Hogarth Press, London

**Winnicott, DW (1971),** *Playing and Reality*, Tavistock Publications Limited, London

## Appendix 1 – Snap IV Questionnaire

### SNAP –IV Teacher and Parent Rating Scale

Name:\_\_\_\_\_Gender:\_\_\_\_\_Age:\_\_\_Date:\_\_\_\_\_

—

Ethnicity:\_\_\_\_\_

For Teacher: Completed by:\_\_\_\_\_Year:\_\_\_\_\_ Class Size\_\_\_\_\_

Telephone Number of School\_\_\_\_\_

Recommended Times for Follow-up Call:\_\_\_\_\_

For Parents: Completed by:\_\_\_\_\_No. Parents Living in Home:\_\_\_

Family Size\_\_\_\_\_

Period of time Covered by Rating:

Past week:\_\_\_Past Month:\_\_\_Past Year:\_\_\_Lifetime:\_\_\_Other:\_\_\_

For each item select the box that best describes this child. Tick one box,		Not at All (0)	Just a Little (1)	Quite a Bit (2)	Very Much (3)
1	Often fails to give close attention to details or makes careless mistakes in schoolwork, work or other activities				
2	Often has difficulty sustaining attention in tasks or play activities				
3	Often does not seem to listen when spoken to directly				

4	Often does not follow through on instructions and fails to finish schoolwork, chores or duties				
5	Often has difficulty organising tasks and activities				
6	Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g. schoolwork or homework)				
7	Often loses things necessary for tasks or activities (e.g. toys, school assignments, pencils, book, or tools)				
8	Often is distracted by extraneous stimuli				
9	Often is forgetful in daily activities				
10	Often fidgets with hands or feet or squirms in seat				
11	Often leaves seat in classroom or in other situations in which remaining seated is expected				
12	Often runs about or climbs excessively in situations in which it is inappropriate				
13	Often has difficulty playing or engaging in leisure activities quietly				
14	Often is “on the go” or often acts as if “driven by a motor”				
15	Often talks excessively				
16	Often blurts out answers before questions have been completed				
17	Often has difficulty awaiting turn				
18	Often interrupts or intrudes on others (e.g. butts into conversations/games)				

	Sum of items for each scale	Average rating per item for each scale	Teacher 5% Cutoff	Parent 5% Cutoff
Average score for ADHD – Inattention (sum of items 1-9/number of items)			2.56	1.78
Average score for ADHD – Hyperactivity-Impulsivity (sum of items 10-18/ number of items)			1.78	1.44
Average score for ADHD- Combined (sum of items 1-18/number of items)			2.00	1.67

#### Scoring Instructions for the Snap-IV

The 4 point response is scored 0-3 (Not at All = 0, Just a Little = 1, Quite a Bit = 2, and Very Much = 3)

One method of evaluating the SNAP-IV is to look at subscale scores. Subscale scores on the SNAP – IV are calculated by summing the scores on the items in the specific subset (e.g. Inattention) and dividing by the number of items in the subset (e.g.9). the score for any subset is expressed as the Average Rating Per Item

The 5% Cutoff scores for teachers and parents are provided. Compare the Average Rating Per Item Score to the Cut off score to determine if the score falls within the top 5%. Scores in the top 5% are considered significantly deviant.

To meet DDM-IV criteria for ADHD, one must have at least 6 responses of “Quite a Bit” or “Very Much” (scored 2 or 3) to either the 9 inattentive items (1-9) or 9 hyperactive-impulsive items (10-18), or both.

In addition, symptoms must have occurred in childhood, they must impair the child’s functioning in two or more settings, and they must not be primarily due to any other factors or conditions.

Depending on the domains affected, ADHD, predominantly inattentive type, ADHD, predominantly hyperactive-impulsive type, or ADHD combined type may be considered. Using a rating scale such as this, however, is not sufficient in and of itself to diagnose ADHD. Other sources of information should be considered and an appropriate health professional should be consulted.

Adapted from SNAP – IV Teacher and Parent Rating Scale by James Swanson, UCI, Irvine, CA.